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THE DEVELOPMENT OF A SYSTEMIC, TRAUMA-INFORMED GROUP MODEL TO REDUCE SECONDARY TRAUMATIC STRESS AMONG VIOLENCE INTERVENTION WORKERS

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Abstract

ABSTRACT

THE DEVELOPMENT OF A SYSTEMIC, TRAUMA-INFORMED GROUP MODEL TO REDUCE SECONDARY TRAUMATIC STRESS AMONG VIOLENCE INTERVENTION WORKERS

Laura Vega, MSW, LCSW

Lani Nelson-Zlupko, Ph.D., LCSW

Secondary Traumatic Stress (STS) among violence intervention workers is pervasive and increases the risk of negative psychosocial and health outcomes. Compelling evidence demonstrates the virulent impact of STS on individual workers, clients, and organizations (Bride, 2007; Figley, 1995; Pearlman & Saakvitne, 1995). STS is an occupational hazard and organizations have an ethical obligation to implement strategies to address it, ultimately protecting workers and clients. However, research is limited on effective interventions to address this issue, with existing interventions focusing narrowly on self-care strategies. Due to the significant and consistent trauma exposure inherent in violence intervention work, it is essential for STS interventions to be proactive, ongoing, and agency-based. This dissertation identifies key risk and protective factors, reviews existing interventions, and describes gaps in those interventions. The development of a group model, Stress-Less Initiative, is presented, an evidence-informed, theoretically grounded intervention that is proactive, ongoing, and embedded within the organization to prevent secondary trauma. The Stress-Less Initiative is a team-based model that provides a safe context to reflect on the impact of trauma work while increasing collegial support, coping strategies, team cohesion and resilience. Recommendations for agency use of this intervention are provided and implications for practice, research and policy are presented.

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**THE DEVELOPMENT OF A SYSTEMIC, TRAUMA-INFORMED GROUP
MODEL TO REDUCE SECONDARY TRAUMATIC STRESS AMONG
VIOLENCE INTERVENTION WORKERS**

Laura Vega, MSW, LCSW

A DISSERTATION

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Dedication page

I dedicate this dissertation to the memory of my loving mother. Words can never fully capture all she has taught me through her love, perseverance, and sacrifice(s). She instilled in me a love for children, a passion for service, and faith in healing. To my husband, Rolando and my daughter, Alexandria, you have filled my life with such love and happiness. I thank God for you each day.

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CHAPTER 1: Introduction

Statement of the Problem

Over the past 20 years, there has been a strong call to action to address the role that trauma plays in the lives of children and families across many systems of care. This growing awareness of the significant impact of trauma exposure has led many programs to adopt and implement trauma-informed policies and practices, leading to an increase in screening and treatment for children presenting with acute and complex trauma symptomology (Branson, Baetz, Horwitz, & Hoagwood, 2017). One implication of this movement is that many of the increased efforts to identify and treat trauma-exposed youth result in frequent exposure of professionals and paraprofessionals to significant amounts of direct and/or indirect traumatic material. Charles Figley (1995) first called this experience secondary traumatic stress (STS).

STS is defined as the “emotional duress that results when an individual hears about the first hand trauma experiences of another, and can mimic posttraumatic stress disorder (PTSD) symptoms” (NCTSN, 2011, p.2). Unmitigated STS can lead to PTSD, and can have negative effects on one’s emotional and physical health (Cocker & Joss, 2016). PTSD symptoms include increased arousal and/or avoidance symptoms and re-experiencing (Sprang, Craig, & Clark, 2011). In addition, such exposure impacts workers’ safety and wellbeing, as well as that of their families, the people they care for, and their employing organizations (Cocker & Joss, 2016).

Violence intervention workers often find great meaning and satisfaction in their work with youth and families (Bell, Kulkarin, & Dalton, 2003). They also hear and

witness the profound traumatic and emotional experiences of their clients and families daily. Exposure to trauma, as well as the need to recount these experiences for documentation, supervision, and client advocacy places workers at an increased risk for STS (NCTSN, 2011). In community agencies with limited resources and taxed systems, frequent and ongoing traumatic impact on workers becomes compounded and pervasive (Bell, Kulkarni & Dalton, 2003).

Although prevalence studies reveal variations of STS symptoms across professional groups, settings, and client populations, research clearly demonstrates an impact. An estimated 40% of social workers experience moderate to high levels of STS (Cornille & Meyers, 1999; Dalton, 2001). Conrad and Keller-Guenther (2006) found that almost 50% of child protection workers in Colorado had a high risk of STS, while Ben-Porat and Itzhaky (2009) found moderate levels of STS symptoms among professionals working with victims of family violence. Trauma therapists in Europe reported high frequency of STS symptoms, compassion distress, and burnout (Deighton, Gurriss, & Traue, 2007). Despite variations in prevalence of STS, these studies clearly indicate the need to address this issue across many disciplines and client populations.

As prevalent and pervasive as the effects of STS are on individual workers, clients, and organizations, there exists a gap of effective interventions to support professionals in their work with victims of violence (Cocker & Joss, 2016). Research is limited on effective interventions to address this issue, with existing interventions focusing narrowly on self-care strategies. The Stress-Less Initiative (Vega, 2017) was developed as a systemic group intervention model to close this gap in preventative interventions.

This dissertation a) describes the impact of STS on violence intervention workers, clients, and organizations, b) highlights the risk and protective factors for STS, c) reviews existing interventions to address STS, and d) proposes an organizationally embedded, ongoing group model to prevent and reduce STS. The Stress-Less Initiative (Vega, 2017) integrates evidence-based best practices with theoretical principles to produce a strengths-based, trauma-informed intervention with clear guidelines for implementation. This dissertation includes a framework for understanding the organizational factors that contribute to STS, and can assist supervisors and administrators who want to implement an evidence-informed, theoretically grounded intervention aimed at the prevention and reduction of employee's STS symptoms.

This dissertation is organized into seven chapters. Chapter one focuses on the background and significance of STS. It clearly defines related constructs and describes the prevalence and impact of STS on individuals, families, and organizations. Chapter two reviews the literature on stress and trauma and provides an ecological framework to understand the impact of STS on the individual, interpersonal, organizational, and societal levels. Chapter three provides a comprehensive review of literature on the risk and protective factors for STS. Chapter four examines the strengths and limitations of existing interventions, and identifies key principles and conceptual frameworks of highly effective interventions. Chapter five introduces a specific group model, the Stress-Less Initiative (Vega, 2017), and provides an overview of the model's goals, key assumptions, session components, and content. Chapter six provides recommendations on implementation of the model, and Chapter seven concludes with the implications for research, practice, and policy.

Background and Significance

STS, compassion fatigue (CF) and vicarious trauma (VT) are all terms used to describe or explain the negative impact individuals experience as a result of their work with trauma-exposed clients. These conditions have increasingly been recognized in the mental health field as a considerable risk for individuals who work with trauma survivors (Dunkley & Whelan). In the literature, these terms are often used interchangeably or used ambiguously (Boscarino, Adams, & Figley, 2010; Jenkins & Baird, 2002). While some ambiguity still remains among these terms, there appears to be consensus in the field that those who work with trauma victims experience emotions and symptoms similar to, or evoked from, their clients' traumatic experiences. While burnout is another related construct, it has not been linked to the presence of trauma exposure in one's environment.

Maslach and Jackson first identified the construct of burnout (Maslach & Leiter, 1997). Maslach (1976) defines burnout as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do work of some kind" (p.3). Burnout has been conceptualized as a process rather than a condition, and some have theorized that it progresses through emotional exhaustion, depersonalization, and reduced personal accomplishment. In several studies, burnout and general stress levels were not related to exposure to traumatized clients, whereas measurements of trauma exposure and vicarious trauma were related (Farber, 1985; Kassam-Adams, 1995). In earlier research, burnout was seen as an individual issue, but current research has now been expanded to include organizational factors. Unsupportive administration, lack of professional challenge, low

salaries, and difficulties encountered in providing client services are predictive of higher burnout rates (Arches, 1991; Beck, 1987). However, burnout is a distinct construct from STS.

McCann and Pearlman first conceptualized vicarious traumatization (VT) in 1990, when they referred to VT as “a transformation in the therapist’s (or other trauma worker’s) inner experience resulting in empathic engagement with the client’s trauma material” (Pearlman & Saakvitne, 1995, p.31). McCann and Pearlman describe the pervasive effects of frontline trauma work on the identity, world view, psychological needs, beliefs, and memory system of the therapist. They identify five key areas of cognitive schemas that are changed by exposure to trauma: trust, safety, control, esteem, and intimacy. Originally, VT was defined to include the trauma reactions of therapists; however, current literature focuses on trauma workers’ cognition over time resulting from ongoing exposure to traumatic materials (NCTSN, 2011). However, there are many similarities and overlap regarding the intersection of VT and STS.

Figley (1995) originally identified and defined the concept of secondary traumatic stress (STS) when referring to sexual assault survivors and combat veterans’ significant others. STS is defined as a reaction to indirect exposure to traumatic events experienced by another (Bride, Radey, & Figley, 2007). By the 1990s, researchers examined the effects of traumatic stress on therapists and identified predictors and correlates of STS in psychotherapists and mental health counselors (Brady, Guy, Poelstra & Brokaw, 1999), sexual assault counselors (Shauben & Frazier, 1995), and trauma therapists (Arvay & Uhlemann, 1996; Pearlman & Mac Ian, 1995). Collectively, these studies provide

empirical evidence that individuals who provide direct services to clients exposed to trauma are at risk of experiencing symptoms of traumatic stress themselves.

Joinson (1992) first used the term compassion fatigue (CF) while studying burnout in emergency department nurses as he sought to de-stigmatize the concept of STS because he viewed STS as a normative occupational hazard for trauma workers. Figley (2002) described CF as a form of caregiver burnout. He defines CF as the stress connected with the level of empathic engagement the worker has to the victim or client. In much of the literature, STS and CF have been used interchangeably, and refer to the existence of PTSD symptoms as a result of exposure to another's traumatic material.

In the 1990s, researchers examined the unique impact of trauma work and used the posttraumatic stress model to explain the stress and symptomology helpers develop when exposed to traumatic material in the workplace. There is agreement among researchers that STS, CF, and VT all result from exposure to trauma work. All of these concepts share the assumption that the impact of traumatic material upon the service provider can mimic the experience described by trauma survivors, although typically in decreased intensity (Kulkarni, Shanti, & Bell, Holly, 2012). For the purpose of this dissertation, we will use the general term "secondary traumatic stress" to include CF and VT, and to refer to the adverse reactions in the context of their work with trauma survivors. Next, we will examine the impact of STS on individual workers, clients, and organizations.

Prevalence and Impact of Secondary Traumatic Stress

The high rate of adversity and increased symptomology trauma workers experience led to recent revisions to the diagnostic criteria for PTSD in the fifth addition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5, 2013). PTSD Criterion A specifically describes STS, as repeated exposure to the aversive details of a traumatic event during the course of one's professional duties (American Psychiatric Association, 2013). PTSD symptoms include:

- Re-experiencing (unwanted upsetting memories, nightmares, flashbacks, emotional distress after exposure to traumatic reminders and physical reactivity after exposure to traumatic reminders)
- Avoidance of trauma-related stimuli (trauma-related thoughts and feelings, trauma-related reminders)
- Negative thoughts or feelings that occurred after the trauma (inability to recall key features of the trauma, overly negative thoughts and assumptions about oneself or the world, exaggerated blame of self or others, negative affect, decreased interest in activities, feeling isolated, and difficulty experiencing positive affect)
- Trauma-related arousal and reactivity that worsened after the trauma (irritability or aggression, risky or destructive behavior, hypervigilance, heightened startle reaction, difficulty concentrating, and difficulty sleeping) (DSM-5, 2013).

The “essential difference between [traditional] PTSD and STS lies in the fact that the primary victim is traumatized by a particular event, or series of events, whereas the caregiver or helping professional is traumatized by helping or wanting to help the primary victim and in doing so becomes exposed to the original trauma(s) (Figley, 1995)”. The helper may begin to experience symptoms consistent with PTSD. However, there have been few studies that have documented the prevalence of individual STS symptoms and the frequency to which diagnostic criteria for PTSD are met.

Bride (2007) demonstrated that the rate of PTSD in social workers is twice that of the general population. Bride studied the prevalence of STS among social workers,

examined the frequency of individual symptoms with which diagnostic criteria for PTSD are met, and the severity of STS levels. Six hundred master's-level social workers completed surveys and reported on age, gender, ethnicity, length of social work experience, number of hours worked, field of practice, and typical work-related tasks. Respondents rated the extent to which their client population was traumatized, the degree to which the respondent's work addressed issues related to client traumas, and the extent to which the respondent experienced fear, helplessness, or horror in response to the traumatic experiences reported by clients. Lastly, respondents completed the Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004).

STSS, a 17-item, self-report instrument, assessed the frequency and duration of intrusion, avoidance, and arousal symptoms associated with STS (resulting from working with traumatized populations). This study revealed that despite working with traumatized clients, nearly 45 percent of workers did not meet the diagnostic criteria for PTSD (other than exposure). However, 55 percent of the sample met at least one PTSD criteria, 20 percent met two criteria. While the lifetime prevalence of PTSD in the general population due to all traumas is estimated to be only 7.8 percent (Kessler et al., 1995), 15.2 percent of front-line social workers met all three core diagnostic criteria for PTSD.

Repeated exposure to the graphic retelling of trauma stories and witnessing the emotional aftermath of violence has a cumulative effect over time and correlates with changes in the worker's sense of intimacy, trust, safety, connection, and sense of self (NCTSN, 2011). Victim stories shared with social workers include vivid descriptions of a traumatic experience, sometimes including reports of human-induced cruelty and abuse that can elicit strong emotional reactions from clients (Figley, 1999; Pearlman &

Saakvitne, 1995a). Figley (1995) categorized the effects of working with trauma survivors into three categories: indicators of psychological distress or dysfunction, cognitive shifts, and relational disturbances. Figley's description supports the complex interplay of trauma and its impact on one's emotional, cognitive, and relational health. In addition to these factors, STS contributes to many physical health problems for staff, including: exhaustion, muscle pain, headache, insomnia, respiratory distress, hypertension, and gastrointestinal disorders (CDC, 2008; Felton, 1998; Van Liew, 1993).

In addition to the negative sequela in individual workers, STS impacts the care provided to clients and families. Dutton and Rubinstein (1995) assert that defense mechanisms, such as detachment and non-empathic distancing used by workers to deal with client's traumatic experiences, lead to clients feeling emotionally isolated and detached from those workers who are trying to help them. STS also contributes to victim blaming (Austin, 1997) and the disruption of empathic abilities (Pearlman & Saakvitne, 1995). Bride (2007) found that 31.6 % of workers endorsed client avoidance (reduced interactions or visits with clients) which was the second most frequently reported symptom. The Bride findings are particularly alarming considering how such symptoms not only affect workers, but also directly impact the quality of care provided to clients. Compromised care may negatively impact vulnerable children and families; and may also increase risks related to safety for staff, clients and the organization.

STS also correlates with low rates of job satisfaction, retention, employee engagement, decreased agency efficiency, morale, quality of work, increase in staff turnover, and economic loss to the agency associated with hiring and training rates (Joyce et al., 2015). Mental health is an increasingly important topic in the workplace with

common psychological disorders now recognized as the leading cause of sickness absence and long-term work disability in most developed countries (Moncrieff & Pomerleau, 2000; Shiels et al. 2004; Black, 2008; Harvey et al. 2009; Cattrell et al. 2011; Murray et al., 2012). Stress-related health conditions contribute to substantial economic costs to employers and disruptions in quality services provided to vulnerable children and families.

The physical, psychological, cognitive, and behavioral manifestations of STS also interfere with worker productivity as workers perform their job duties, while also trying to address their own health needs. STS is pervasive and increases the risk for negative psychosocial and health outcomes for workers, negatively impacts client safety and wellbeing, and poses great economic strain on the organization. Abounding risk factors in multiple domains highlight the need for a holistic and comprehensive understanding of the interrelated factors that increase risk for STS. Next, we will apply the Social Ecological Model to challenge previous assumptions regarding STS, and review the risk and protective factors which will inform the development of the proposed treatment intervention.

CHAPTER 2: Correlates of Stress and Secondary Trauma Using an Ecological Framework

Stress and Trauma

Understanding stress and one's ability to cope in the face of stress is essential to disease prevention. Stress contributes to illness through its direct physiological effects or indirectly impacts individuals in the presentation of maladaptive health behaviors (Glanz & Schwartz, 2008). Stressors, demands made by the internal and external environment, upset balance or homeostasis, and negatively affect physical and psychological well-being (Lazarus & Cohen, 1977). The stress response system is a combination of physical reactions, thoughts, emotions and behaviors. There are four types of stress reactions; positive stress, tolerable stress, toxic stress, and traumatic stress (Bloom, 2013).

Positive stress produces short-lived physiological responses that promote growth and change and are necessary for healthy development. Tolerable stress, a more intense stress response, occurs as the result of a more severe, longer-lasting difficulty, and if the activation is time-limited, and sufficient social support buffers the individual's central nervous system, the brain and other organs recover without long-term negative effects. On the other hand, toxic stress is associated with prolonged and intense activation of the body's stress response to such an extent that changes occur in the architecture of the brain with problematic long-term consequences (Bloom, 2013). Traumatic stress occurs when a person experiences or witnesses an event that is overwhelming, usually life threatening, terrifying or horrifying in the face of feeling helplessness (Perry, 2007). As with toxic

stress exposure, the effects of traumatic stressors are multi-determined and therefore are highly individual (Bloom, 2013).

Traumatization occurs when both internal and external resources are inadequate to cope with real or perceived external threats (Van der Kolk, 1989). Research demonstrates that exposure to traumatic stress may result in negative long-term consequences, including biological impairments, even though the physiological stress response system seeks to promote human survival (Cohen, Manarino & Deblinger, 2006). The basic internal physiological protective mechanism, present in all mammals, is called "the fight-flight-freeze" response (Cannon, 1939). In the fight or flight response, the body releases hormones and other chemicals, that stimulate the body's survival systems. For example, the stress response system activates the heart rate, blood pressure, and respiratory rate, and increases alertness and vigilance (Perry, 2007). At the same time, a decrease occurs in feeding, reproductive activity, and immune response, conserving energy for survival. A typical and normative stress response is time-limited, and is effective; it is life-saving and highly adaptive (Perry, 2012). Problems arise when the body's stress response system activates in the absence of any threat, when the threat is prolonged, or when the individual feels helpless in the face of the threat. Under these conditions, the stress response hormones overwhelm the body and brain, and cause potential long-term and serious damage (Perry, 2007).

While the stress response system is lifesaving in a true emergency, under conditions of chronic stress, something goes wrong. This process is referred to as allostatic load, and refers to the long-term effects of the continued exposure to chronic stress on the

body as the body attempts to cope with a chronic overload of physiological responses. The effectiveness of the response diminishes, and the body becomes desensitized to some of the effects of the neuro-hormones and hypersensitive to others, resulting in a set of highly dysfunctional and maladaptive brain activities (Perry & Pate, 1994; Perry, 2007). The individual experiences a state of chronic hyperarousal. Essentially, the individual's arousal baseline changes and the individual loses control of their responses to stimuli (Bloom, 2013). With each fight-or-flight experience, the mind develops trigger responses, as the brain forms a network of connections and set responses in the face of specific circumstances (Cohen, Mannarino & Deblinger, 2006). In the same way individual clients may experience the persistent fight or flight response, there exists a parallel process in which workers can experience the same response as a result of their increased and chronic exposure to traumatic stress.

In the face of increased stress, protective factors may decrease the negative impact of traumatic stress. For example, support from friends, family, and providers may profoundly decrease the negative effects on psychological and physical outcomes. How individuals appraise and experience stress affects how they will access care and social support. One's reactions to stress can either promote or inhibit healthful practices (Glanz & Schwartz, 2006). When a stressor is perceived as highly threatening and uncontrollable, a person may be more likely to use disengaging coping strategies (Taylor et al., 1992). Examples of disengaging strategies include distancing, cognitive avoidance, behavioral avoidance, distraction, and denial (Glanz & Schwartz, 2008). Avoidance and denial may temporarily diminish the initial distress, but over time can lead to higher

levels of distress and maladaptive behaviors (Carver et al., 1993). The extant literature illustrates how a protective factor such as social support may interrupt the deleterious effects of stress; interventions aimed at decreasing stress reactions should include methods to increase utilization of social support. Current research indicates that social integration, support, and finding meaning and purpose in life are known protective factors against allostatic load (Seeman, Singer, Ryff, Dienberg, & Levy-Storms, 2002).

A number of theories, including the Theory of Interpersonal Neurobiology (Siegel, 1999), the Transactional Model of Coping (Lazarus & Cohen, 1977), and the Buffering Hypothesis (Cohen & Wills, 1985) address the interplay between internal and external factors, and an individual's response to traumatic stress. These theories provide the framework for understanding the multifaceted impact of trauma, and also highlight the essential components to mitigate its impact.

Dan Siegel's Theory of Interpersonal Neurobiology (1999) proposes that the interpersonal relationship directly shapes the neurobiological state of the brain within interactions with others. This theory integrates our individual biology and our environment and proposes that our experiences throughout life shape the functioning of the mind. As applied to STS, this theory suggests that intervention should address traumatic stress reactions through the integration of thoughts, feelings, body reactions (and body memories), and behaviors.

The Transactional Model of Stress and Coping (TMSC) is a theoretical framework for evaluating processes of coping with stressful experiences. TMSC construes stressful experiences as person-environment transactions, in which the impact of an external stressor, or demand, is mediated by the person's appraisal of the stressor

and the psychological, social, and cultural resources at his or her disposal (Lazarus & Cohen, 1977). When faced with a potential stressor, a person evaluates potential threats or harms (primary appraisal), along with his or her ability to alter the situation or manage negative emotional reactions (secondary appraisal). For example, the social support that an individual has available can actually change their perception of the stressful event because with increased social support, the individual feels an increased ability to overcome the challenge or threat. “That is, the perception that others can and will provide necessary resources may redefine the potential for harm posed by a situation and/or bolster one’s perceived ability to cope with imposed demands, and hence prevent a particular situation from being appraised as highly stressful” (Cohen & Wills, 1985, p.312). Effective interventions aimed at reducing stress should include recognition of protective factors, such as social support, to target primary appraisals.

The Buffering Hypothesis relates to the individual’s perception of a situation once deemed stressful or threatening; for example when an individual perceives that it is important to respond, but an appropriate response is not immediately available (Cohen & Wills, 1985). Characteristic effects of stress appraisal include negative affect, elevation of physiological response, and behavioral adaptations (Baum, Singer & Baum, 1981).

Although a single stressful event may not place great demands on the coping abilities of most individuals, when multiple problems accumulate, persisting and straining the problem-solving capacity of the individual, the potential for serious disorder occurs (Wills & Langner, 1980). Adequate social support may intervene between the experience of stress and the onset of the pathological outcome by reducing or eliminating the stress reaction or by directly influencing physiological processes (Cohen & Wills, 1985). While

acknowledging that there are individual factors that can increase one's resilience, these theories encompass the significance of social support and environmental factors in reducing the negative psychosocial and health consequences of stress.

The Social Ecological Model

The Social Ecological Model (SEM) is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational elements for health promotion within organizations. The Center for Disease Control (CDC, 2002) uses a four-level social-ecological model to better understand violence and the effect of potential prevention strategies. SEM considers the complex interplay between individual, relationship, community, and societal factors. A full understanding of the complex nature and prevention of STS requires an examination of the dynamics at play in each level and how they intersect and contribute to increased levels of STS.

The individual level of the Social Ecological Model accounts for an individual's biological makeup, personality, and coping style, and includes an individual's beliefs, values, culture, and history since these factors play into how an individual behaves and responds in his or her own environment. The interpersonal level refers to the social supports available to an individual. The amount of support available, as well as how individuals utilize their resources and support system contribute to, or reduce STS (Cocker & Joss, 2016).

The community level of the SEM relates to relationships among organizations, and informal networks within defined boundaries, including the environment (CDC,

2002)). There are many known organizational correlates of STS (that will be reviewed later in this chapter). The final level of the SEM is the societal level which is defined by local, state, national and global laws and policies, including policies regarding the allocation of resources (UNICEF, 2017). Each level is discussed here.

Individual

In our society, the negative effects of stress are most often attributed to individual deficits in one's ability to cope. Becker (2012) describes two themes that dominate the American progress and pathology story. The first theme asserts that "excessive anxiety is damaging, and that the damaging effects of worry increase as the pace of life increases" (Becker, 2000). The second theme is that "all of us are individually responsible for managing ourselves so that we make a reasonable adjustment to the conditions of modern life, however stressful" (Becker, 2000). The damage scenario emphasizes the possibility that society can destroy our health and well-being; the adjustment scenario emphasizes the possibility that if we fail to adapt to the conditions imposed by our culture we will ruin ourselves" (p. 20).

Both conditions underpin the existence of STS. When individuals experience high levels of stress and anxiety from engaging in intense trauma work, they face the reality that stress can negatively affect their health, while also feeling solely responsible for controlling, fixing, and enduring circumstances that are often outside of their control. In their book, *Transforming the Pain*, Saakvitne & Pearlman (1996, p. 162) express that the mental health field often subscribes to this idea of blaming professional helpers if they are "unable to adjust to extreme stress....drawn in part from the medical model-that

a professional doesn't get involved and that his or her feelings are signs of weakness, inadequacy, or poor boundaries". Jorgenson's work (2012, p.54) provides support as she states, "STS is often surrounded in silence and shame as professionals avoid speaking up due to fear of being pathologized".

A fine line exists differentiating stress from trauma. Van der Kolk (1989) describes a lack of capacity to tolerate or mitigate the effects of events that are occurring in the external environment; however STS is a condition that has traditionally problematized helpers as having individual deficits. In Van der Kolk's definition of traumatization, he acknowledges the existence of external/social resources that may be available to individuals to alleviate or reduce trauma symptoms, but he does not address how the social environment can, in fact, create the stress and traumatization. Instead of focusing on changing the structural factors causing stress, our society places the onus and blame on the individual for their inability to effectively manage the stress (Becker, 2000). This in turn increases stigma and deters individuals from utilizing support.

In her substantial work on trauma and PTSD, Judith Herman (1992) states that trauma is experienced as a "loss of control, sense of chaos, and a lack of predictability." Ironically, Herman's explanation of the trauma experience describes the unpredictability of a typical day as a frontline violence intervention worker; and the systemic and structural barriers that interfere with effective treatment and result in social injustice. Regardless of a client's hard work or commitment to recovery, limitations persist (Kulkarni, Shanti, & Bell, 2012). Social injustice, coupled with the complex adversity clients face, often leave frontline workers feeling out of control and ineffective (Bell, Kulkarni & Dalton, 2003). In addition, workers struggle with balancing just the right

amount of connection with (empathy) and separation from clients so that they do not feel the same sense of chaos that clients try so hard to avoid. Some frame trauma as a ‘contagion’ to depict the way that trauma has the power to affect individuals, families, staff, administrators, organizations, and our community (Bloom, 1995).

Interpersonal

The next level of the Social Ecological Model is the interpersonal level which includes an individual’s interpersonal relationships and social support structure. Several factors may impede a worker from utilizing their supportive resources. Trauma workers often find it difficult to discuss the intensity of their work with close friends and family. There are three main reasons for this- 1) the responsibility to maintain client confidentiality which limits what workers can discuss with others; 2) the fact that those who do not engage in this work may not understand (Choi, 2011); and 3) the understandable desire to protect loved ones from the trauma material. These factors can often lead violence intervention workers to feel isolated and invalidated (Choi, 2011). Even if workers have extensive social support available to them, they may not utilize this support or the specific types of support they need to mitigate the effects of trauma may not be present. For these reasons, and to best support workers, prevention strategies at this level should include peer support programs designed to reduce stress, foster problem solving skills, and promote healthy relationships (CDC, 2002).

Community

Community, the third level of the SEM, is defined as relationships among organizations, institutions, and informational networks within distinct boundaries,

including the built environment (UNICEF, 2017). Understanding the complexity of STS requires consideration of the work environment and the community in which the work is taking place. The impact of community factors on the development of STS has been widely neglected in the current literature. In the violence intervention sector, workers advocate for some of the most vulnerable children and families, those that live in extreme poverty, and experience racism and systemic oppression. Violence intervention workers witness their clients' traumatic events and experience the structural elements of oppression and discrimination that can leave vulnerable children and families subjugated. These elements permit the chronicity of the trauma or fail to protect children and families from it, adding another layer of injustice that is often difficult for workers as it often conflicts with workers' roles, expectations, values, and beliefs. Violence intervention workers may or may not personally experience the same level of classism, racism, sexism and oppression as their clients, but their valiant efforts to positively affect system and structural change can be limited, leaving workers feeling ineffective and helpless when advocacy efforts do not lead to desired outcomes for families (Kulkarni, Shanti, & Bell, Holly; April 2012). Prilleltensky & Prilleltensky (2005) discuss the need for caring professionals to blend caring work with justice work in efforts to mitigate the risks that confront marginalized populations. While workers strive for overall wellness for clients, this goal is impeded without systemic changes to larger issues of social injustice.

A leading thinker in the area of trauma-informed organizations, Sandra Bloom (2017) states that organizations like individuals, are living, complex, adaptive systems and that being alive, they are vulnerable to stress, particularly chronic and repetitive stress. A parallel process, a reference to experiences of transference and countertransference

amongst sub-systems within an organization, exist in every organization (Vargas & Bloom, 2007). With regard to traumatic stress, trauma reactions of clients and staff can translate to administrators and the overall organization in the absence of systemic strategies to mitigate the effects of trauma. Without preventative systems in place, such an organization is likely ill-equipped when safety concerns arise, lacks effective communication, is reactive, and is authoritarian, further creating division, isolation, poor decision-making, and perpetuates trauma within the organization, and potentially to other external community providers (Bloom, 2017).

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA, 2018, p. 9) concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

SAMHSA also states that a trauma-informed approach can be implemented in any type of service setting or organization. While many organizations consider themselves to be utilizing a trauma-informed approach with the focus on clients or patients they serve, such organizations often overlook the needs of staff related to recognizing the signs and symptoms of vicarious trauma. Organizations must understand and address how trauma work impacts staff in order to prevent client re-traumatization (Bloom, 2006).

Prevention strategies at this level impact the social and physical environment – for example, by reducing social isolation, improving the work climate, processes, and policies within workplace settings (CDC, 2002). The community and organizational factors that impact STS support the strong need for interventions embedded within the organization to best support workers, reduce stigma associated with STS, and to address the factors that pose the greatest risk. STS affects individuals, however, many external factors and conditions create an environment for stress and trauma to permeate. An understanding of STS requires us to examine these concepts in the context of our current cultural, political and social climate.

Societal

The Social Ecological Model's fourth level addresses broad societal factors, which include health, economic, educational and social policies (CDC, 2002). Kirmayer, Kienzler, Afana, & Pedersen (2010) state that “the contexts in which trauma experience is embedded and from which it emerges are multiple, and include biological processes of learning and memory; embodied experiences of injury, pain, and fear; narratives of personal biography; the knowledge and practices of cultural and social systems; and the power and positioning of political struggles enacted on individual, family, community and national levels” (p. 170). This depiction of the trauma experience and its complexity supports the need for trauma interventions to target multiple levels. Historical, social, political, and economic factors directly impact the amount of trauma that exists in society which then impacts the amount of exposure for workers. If one wants to mitigate the

effects of STS, it is important to also examine the limitations of existing policies that impact resources and services for workers, clients and families.

Social factors influence the risk of exposure to trauma and also inform the likelihood of being negatively affected as well as the likelihood of receiving effective treatments (Nicolas, Wheatley, and Guillaume, 2015). Violence disproportionately affects minority populations and low income urban communities. Homicide is the second leading cause of death in individuals 15-24 years, and the main cause of death among African Americans aged 10-24 years (Aboutanos et al., 2011). Minority populations living in urban communities face chronic adversities rooted in histories of colonialism, oppression, poverty, and environmental degradation. When emphasis is placed only on the current trauma experience, this de-emphasizes the stresses influenced by long standing histories of racism, economic domination, and political oppression (Nicolas, Wheatley, & Guillaume, 2015). When violence intervention workers advocate for youth and families, they are not only affected by a client's traumatic material, but also impacted by the limitations in policies, systems, and laws that continue to create disparities between those of privilege and those without.

Capitalism and neoliberalism created an infrastructure that breeds inequality and promotes systemic oppression in America. Our federal, state, and local laws include policies that allow for the discrimination and marginalization of individuals based on socioeconomic status, race, gender, and abilities. An examination of STS at the societal level underscores the devastating impact of current laws and policies as they relate to the children and families served in urban communities, and the lack of resources and

protection available to them. They impact the individual, interpersonal, community, and organizational aspects of the structural and systemic change we want for our clients.

Prilleltensky & Prilleltensky (2005) assert that resilience must go beyond being a phrase about how individuals cope with adversity. It must entail a challenge to the very structures that create inequality. It is a call to action for a more caring and just society to create the conditions for resilience to be experienced. As we critically examine the conception of STS and what is needed to reduce it, we also need to find solutions that create environments and cultures that support recovery and for individuals to be successful.

This ecological view of trauma and STS challenges traditional assumptions regarding the conceptualization of resilience. An examination focused solely on individual factors of resilience undermines the social and relational influences that can create environments for individuals to flourish. We need to integrate this knowledge about multi-level interventions into effective interventions to address STS, and stress the importance of the organizational climate and environment to positively impact the health and wellness of its employees. The following chapter presents individual and organizational factors that can increase/decrease risk for STS, which have been integrated into the development of the proposed intervention (discussed later in Chapter 5).

CHAPTER 3: Risks and Protective Factors

The causes of STS have been given significant attention in the literature. However, causation remains unclear as much of the research demonstrates only strong correlation with a number of variables that have been studied. Current research takes a critical look at exploring additional external variables, thus leading to other explanations as to why some workers develop STS and why some do not. Since empirical research on causes and correlates should inform the development of interventions, a review of the literature recognizing the risk and the protective factors for the development of STS symptoms was essential in the development of the proposed STS intervention.

In order to explore who is at the greatest risk for developing STS in the workplace, a comprehensive review of empirical studies was conducted. A meta-analysis by the Center for Research on Employment and Workplace Health in Canada explored risk factors related to STS. The 38 studies examined professional groups who experienced indirect trauma in the workplace including volunteers, professional counselors and therapists, school personnel, child protective or welfare workers, domestic violence workers, mental health clinicians (including physicians and nurses), and chaplains. The study identified seventeen risk factors assessed in prior studies including: age; case load frequency; caseload ratio; caseload volume; emotional involvement; ethnicity (Caucasian vs. other); experience; gender; personal trauma; trauma same as client; posttraumatic growth; social support; supervision; supervision quality; trauma

training; and work support. Significant results for predictors of STS were caseload, personal trauma, work support, and social support (Hensel, Ruiz, Finney, & Dewa, 2015).

Only one of four factors identified in this meta-analysis as a significant predictor of STS was personal trauma history, and was individually based. The other 3 significant factors (caseload, work support and social support) can all be adapted on an organizational level. Next, we will review the connection between having a personal trauma history and the relationship to secondary trauma.

Connection between Personal Trauma History and Empathy

In a study that explored the relationship between personal trauma history and STS, Jenkins & Baird (2002) found high effect sizes among therapists with a history of sexual or domestic abuse and who were supporting sexual or domestic violence victims. Nelson- Gardell and Harris (2003) found similar results among therapists with a history of childhood trauma, and who worked with children. In addition, high levels of empathy, particularly the experience of empathic distress in reaction to clients' traumatic experiences, emerged as a risk factor that may interact with personal trauma history. In a study by MacRitchie and Leibowitz (2010), researchers analyzed 64 self-report questionnaires to explore the psychological impact on trauma workers who work with victims of violent crimes, specifically focusing on level of exposure to traumatic material; level of empathy; and level of perceived social support and their relationship to STS. They found that empathy accounted for the association between previous trauma exposure and STS, such that higher levels of empathy increased the level of STS. However, the evidence implicating personal trauma history as a risk factor may not

account for successful resolution of the issues involved. Resolution and meaning making in the aftermath of trauma is a hallmark of trauma treatment and can be associated with decreased levels of traumatic symptomology (Resick, Monson, & Chard, 2016). Further research is needed to better understand the relationship between personal trauma history, empathy, and risk for STS.

This body of research suggests the need to understand the degree to which trauma workers have experienced significant personal trauma histories. The Adverse Childhood Experiences (ACE) research identifies traumatic stressors as leading contributors to social, emotional, medical and cognitive impairment throughout the lifespan (Anda et al., 2006; Felitti et al., 1998). The epidemiologic data from the ACEs research was based on a retrospective and prospective analysis in over 17,000 individuals, and established that exposure to early traumatic stressors sets the stage for a range of negative outcomes across multiple life domains (negative medical and psychological outcomes, sexual behavior issues, healthcare costs, and life expectancy). Most importantly, the finding from the ACE studies revealed a need for an integrated approach with regard to trauma interventions. The ACE literature offers compelling evidence for the idea that traumatic experiences are processed in a complex and multidimensional way, involving multiple levels of cognitions, emotions, behaviors, and body reactions. Therefore, conclusions from the ACE studies highlight that in order to fully recover from traumatic exposure, multiple points of intervention need to be enacted.

An exploratory study by Esaki and Larkin (2013) was the only study of its kind to examine the prevalence of adverse childhood experiences (ACEs) among workers in an agency that provides residential treatment, day treatment, and schooling for children with

reported trauma histories. The original ACEs survey identified adverse childhood experiences such as physical and/or sexual abuse, physical and/or emotional neglect, or living with a parent or caregiver who experienced domestic violence, mental illness, incarceration, divorce/separation, or struggled with drugs and alcohol use (Felitti et al., 1998). Results of the Esaki and Larkin study suggest a high prevalence of ACEs among workers with approximately 70% of workers that reported at least one ACE category, 54% reported two or more, and nearly 16% reported 4 or more categories. The higher rate of ACEs among this population may be related to social worker career self-selection since previous research established a connection between choices of social work career with earlier life trauma (Lyter, 2008). The Esaki and Larkin findings support the need to increase support for workers who may have personal trauma histories, and interventions should incorporate education and training with a focus on connecting one's personal experiences to the work, building resilience, and empathic engagement. In summary, strategies that target both workers' use of empathy and personal trauma history may help to prevent STS.

Caseload Size Matters

In addition to personal trauma history and empathy, extensive research demonstrates that the larger one's caseload is or the proportion of time spent working with trauma survivors is related to higher levels of STS symptoms (Bober & Regehr, 2006; Brady et al., 1999; Kassam-Adams, 1995; Orllepp & Friedman, 2002; Pearlman & MacIan, 1995). Brady et al. (1999), Kassam-Adams (1995) and Schauben and Frazier (1995) all found that increased distress reported by mental health workers is associated

with the number of treated trauma survivors seen by a therapist. In addition, Schauben and Frazier found that therapists who had a higher percentage of trauma cases on their total caseload reported more disturbed beliefs about themselves and others, more posttraumatic stress symptoms, and more self-reported VT. These results support the increased risk for STS among violence intervention workers whose caseload is often all trauma cases, with limited ability to diversify their roles.

Social Support Mitigates Impact of Secondary Trauma

Social support plays an essential role in the lives of individuals who work with clients who have experienced trauma. Kassam-Adams (1995) conducted a study on 100 psychotherapists who worked in outpatient mental health agencies. Approximately 50% of the participants reported STS symptoms, including symptoms of avoidance and intrusive thoughts. The participants' stress levels were found to be inversely related to the levels of social support they had in their personal and professional lives.

In addition, the use, availability, and quality of supervision has been shown to decrease the negative effects of STS and VT (Brady et al., 1999). Dalton (2001) found that the number of hours of supervision received but also the number of times a social worker received supervision were positively related to low levels of STS. Peer supervision can also ameliorate the effects of STS (Catherall, 1995).

STS research demonstrates that organizational social support decreases the impact of STS. For example, Catherall (1995) found that peer supervision creates an opportunity to share perspective and coping strategies and normalizes the VT experience. Formal programs that offer emotional support, such as structured support groups, also promote

greater well-being in the face of STS (Houck, 2014; Aycok and Boyle, 2009). This is further supported in the burnout (BO) literature and the writings about vicarious trauma (VT) which emphasize the importance of social support within the organization. A study by Slattery & Goodman (2009) found that work and social support variables had a significant effect size on STS. Organizations seeking to prevent or reduce the impact of STS must employ interventions that focus on increasing peer, supervisor, and organizational support that can improve the quality of work and preserve the overall effectiveness of the organization (Dunkley & Whelan, 2006).

These findings further illustrate that there are many organizational factors (caseload, supervision, and social support) that can contribute to STS, despite the usual individual-level focus of the existing STS interventions. These findings support the imperative need for interventions to be embedded within the organization to best support its workers, reduce stigma in accessing services, and to address the factors that pose the greatest risk. STS is a serious work hazard and administrators should pay more attention to the negative outcomes and implications of failing to address STS. Administrators and supervisors must understand that STS is a structural problem, and individual solutions may only buffer the negative outcomes. This can result in both physical and psychological impairment of staff, decreased quality of services to clients, and greater attrition rates and costs to the organization (Cocker & Joss, 2016). While interventions targeted at reducing STS are cited as necessary, research related to the effectiveness of these interventions is in its early stages. Chapter four will explore the current interventions that exist, and examine the current gaps and strengths identified to reduce STS.

CHAPTER 4: Secondary Trauma Interventions: Strengths and Limitations

Despite extensive research over the last decade exploring evidence-based interventions to address trauma, there has been less focus on the effectiveness and accessibility of interventions for STS. For example, Bercier & Maynard's (2015) systematic review of STS interventions could not locate a single study that met acceptable methodological criteria. While a number of existing interventions have been modified and developed to decrease symptoms of STS, little is known about the efficacy of such interventions (Bercier & Maynard, 2015). Generally, STS interventions target a range of different risk factors and levels, are implemented in a variety of settings and are delivered through multiple modalities (Bercier, 2013). An overview of these interventions will be presented below, highlighting both strengths and limitations.

Self-Care Alone May Not Be Enough

Interventions designed to reduce work stress, whether this has been conceptualized as burnout or STS, primarily focus on individual self-care strategies (Lonne, 2003) such as exercise, meditation, healthy eating, increasing positive coping and time management skills. However, research exploring the associations between an array of individual coping strategies and work-related traumatic stress found no significant relationship between the therapists' belief in the efficacy of certain coping activities (e.g., self-care activities, use of supervision, and leisure), the time that therapists actually engaged in the activities, and their traumatic stress scores (Bober & Regehr, 2006). Furthermore, research shows that self-care strategies alone may not effectively target the negative sequela of secondary trauma since people decrease their use of self-

care strategies during times of significant stress (Miller, Donohue-Dioh, Niu, Shalash, 2018). Most organizations encourage self-care, but staff struggling with intense reactions may not be able to utilize these strategies or may require more relational or organizational components to decrease stress (Bell, 2003). Though individual self-care strategies offer many positive benefits, the research reinforces the importance of interventions that focus on increasing regular practice of self-care in addition to targeting the organizational correlates that lead to secondary trauma.

Trauma-Informed Care Training and Trauma Education is Essential

Trauma-specific education or trauma-informed care training may help workers increase their awareness of traumatic stress symptoms, and provide a framework for understanding their experiences. Research shows that professional training in trauma-informed care relates to elevations in compassion satisfaction among mental health workers (Sprang, Clark, & Whitt-Woosley, 2007). Increased levels of compassion satisfaction decrease the impact of secondary traumatic stress (Figley, 1995, Stamm, 2002). In addition, an overwhelming amount of evidence in PTSD research supports the importance of psychoeducation regarding trauma and trauma symptoms (Cohen, Marans & Deblinger, 2006). Psychoeducation intended to normalize trauma reactions as a result of external factors is especially important to trauma survivors and plays a critical role in addressing STS (Pearlman & Saakvatne, 1995). Normalizing and validating trauma reactions for workers may reduce stigma while increasing the likelihood that workers will utilize supportive resources.

Unfortunately, trauma-informed care training and trauma education is not always available or accessible in settings that may need it the most; such as juvenile justice and child welfare facilities where staff often encounter greater trauma exposure. Further, only a small component of trauma-informed care training actually addresses the risks associated with secondary trauma exposure (Marrow, Knudsen, Olafson, & Bucher, 2013).

Historically, agencies implemented a variety of education programs to promote knowledge and skill development in coping, adaptation, and emotional self-care (Meadors & Lamson, 2008). Researchers recommend the integration of compassion fatigue interventions within nursing curricula and medical education programs to increase awareness and provide tools to address the physical, behavioral, and psychological demands associated with caregiving (Houck, 2014). Dalton (2001) found that social workers with master's degrees had lower levels of STS compared with those with bachelor's degrees. This difference suggests that the type of clinical training available in master's programs, may be a missing but important component to reduce STS.

Many organizations recognize the need to provide education and guidelines to encourage self-care. One of the most comprehensive standards to promote self-care was developed by the Green Cross Academy of Traumatology. The Green Cross Academy of Traumatology was originally established to serve a need in Oklahoma City following the April 19, 1995 bombing of the Alfred P. Murrah Federal Building. The Standards of Self-Care is a list of guidelines to support employees' self-care needs. It includes Ethical Principles of Self Care in Practice, Standards of Humane Practice for Self-Care, Standards for Expecting Appreciation and Compensation, Standards for Establishing and

Maintaining Wellness, Inventory of Self Care Practice, and Development of a Prevention Plan (Academy of Traumatology, 1995). As important as education is to understand the potential and normalize STS reactions in the trauma field, training and education may not be available or provide the level of support needed to address trauma reactions in staff. These findings suggest that interventions focused on increasing knowledge around secondary trauma reactions and providing workers with effective strategies to respond to trauma can be protective.

Barriers Exists in Accessing Individual Therapy

There has been some research to suggest that Cognitive Behavioral Therapy (CBT) may help reduce STS. Coady and Lehman (2008) suggest that numerous CBT interventions, such as systematic desensitization, behavioral activation, response prevention, self-monitoring, psycho-education, anxiety/stress management, and cognitive restructuring may decrease the negative impact of STS. When CBT is used with trauma professionals, the intervention focuses on how the professional is perceiving and interpreting their experiences which have a direct impact on their coping skills (Inbar & Ganor, 2003). Although personal therapy may be extremely helpful, not all workers can find or afford that level of self-care (Danylchuk, 2015).

The Accelerated Recovery Program (ARP) was developed specifically to treat compassion fatigue originating from secondary trauma. ARP is a five-step structured therapy that encourages identification of symptoms and triggers, utilization of resources, grounding and containment skills to help control situations and symptoms, self-soothing, boundary setting, internal conflict resolution, and self-care after completion of ARP. Pre/posttest Professional Quality of Life (Hudnall Samm, 2009) scores and Satisfaction

with Life Scale (Diener, Emmons, Larsen & Griffin, 1985) suggest that compassion fatigue symptoms are responsive to ARP treatment (Flarity, Gentry & Mesnikoff, 2013). ARP appears to be a promising integrative intervention for STS, but one caveat of this intervention is that it may not be inclusive of the staff with the greatest need or utilized during real time work crises.

Another promising therapeutic intervention is Mindfulness-Based Stress Reduction (MBSR), which teaches participants to deal with stress, pain, and demands of everyday life through meditation focused on self-awareness related to one's feelings. Cohen and Kratz (2014) demonstrated that participants reported increased patience, calmness, and relaxation as a primary benefit of an 8 week MBSR program. Overwhelming evidence supports the positive impact of mindfulness and its potential in helping individuals cope with STS (Irving, Park-Saltzman, Fitzpatrick, Dobkin, Chen, & Hutchinson 2012). However, it is unknown if these benefits remained after the 8 week intervention was completed, or if the positive outcomes persisted in the face of additional trauma exposure. MBSR is also facilitated by individuals outside of the organization who may not be familiar with the high emotional demands and systemic issues of the work. There are many internal nuances that exist within the work and organization that have a direct impact on levels of STS. Again, most therapies are costly and there is a stigma involved in seeking external services (Cocker & Joss, 216). Placing responsibility for the effects of STS on the individual worker reinforces the idea that STS is a result of an individual deficit, and also undermines the responsibility for agencies to incorporate more systemic interventions into their programs to support the health and wellness of their staff and ensure high quality care to clients.

Brief Interventions May Cause More Harm than Good

Employee wellness programs aimed at reducing STS include health screening, role modeling, mentor programs, and staff retreats (Sinclair, Raffin-Bouchal, Venurator, Mijovic-Kondejewski, & Smith-MacDonald, 2017). While all of these programs may offer some type of benefit to employees, they are time-limited and do not address the ongoing or real-time needs of employees. Employee wellness programs are geared towards the employee identifying the issue and seeking relief on their own. Short-term interventions may temporarily decrease symptoms, but may not provide the ongoing level of support required to adequately address the impact of trauma on workers (Kulkarni, Shanti, & Bell, Holly; April 2012). In settings where we know that trauma exposure is extensive and a constant, we need to implement ongoing supports to prevent and reduce STS.

Another intervention to address STS is Critical Incident Debriefing, which is a brief group treatment approach that is typically limited to one session. Research findings regarding the effectiveness of crisis debriefing are mixed. Neria and Solomon (1999) found that the debriefing method appeared to be effective, based on evidence from non-controlled studies. However, randomized controlled studies found no effect on the reduction of stress symptoms after debriefing, and additionally found that there was an increased psychopathology and increased vulnerability with debriefed subjects (Kagee, 2002).

Crisis Intervention Stress Debriefing (CISD) is an exposure-based method used for emergency service workers who have experienced a particular crisis in the workplace (such as sudden deaths or serious injuries). Treatment requires that staff recall the

specific events of a traumatic experience within 24-72 hours after exposure. The hypothesized goal of the intervention is that as the experiences are recalled multiple times, the negative effects of the memories will decrease while being in a safe environment (Bisson, McFarlan, & Rose, 2000). However, research has proven this to be ineffective and has indicated that CISM can even increase stress symptoms (Regehr, 2001).

Resilience-Focused Interventions Improve Symptoms

Vicarious resilience is a newer concept and is defined by Hernandez, Engstrom and Gangsei (2007) as the “positive effects on helping professionals who witness the healing, recovery, and resilience of persons who have survived severe traumas in their lives.” In an unpublished dissertation, Shew (2010) studied the effectiveness of vicarious resiliency training with 25 professionals who were deemed to be at high risk for developing VT. After four weeks, Shew (2010) found that 71% of the participants reported a positive change in their symptoms. This study suggests that there is tremendous value in acknowledging the strengths and rewards in this challenging work, and incorporating a strengths-based, resiliency framework into effective interventions.

The Sanctuary Model is an integrative, comprehensive framework that addresses the overall impact of trauma and provides a toolkit to guide organizations through the healing process. The toolkit includes; community meetings, safety plans, red flag reviews, S.E.L.F. education and self-care planning. Ideally every person in the organization is trained in the Sanctuary methods and knows how to use the prescribed tools in any given situation (Bloom, 2017). The Sanctuary Model is informed by the scientific study of

attachment and child development and the impact of adversity, toxic stress and trauma on individuals and on groups (Bloom, 2017). Although the Sanctuary Model provides an exceptional framework for understanding the impact of trauma on clients, staff, organizations, and guidelines for creating a safe and healthy work culture, it is costly and therefore not accessible to many organizations (NCTSN, 2008). While some studies demonstrate the benefits of the Sanctuary Model, Sanctuary has not yet been evaluated to understand its impact on staff or organizational climate.

The Power of Mutual Aid

Insurmountable evidence demonstrates the importance of group support within the organization to reduce STS (Catherall, 1995; Munroe et al., 1995; Rosenbloom et al., 1995). Opportunities for staff to debrief informally and process traumatic material with supervisors and peers provide much needed stress relief (Cadell, 1999). Catherall (1995, p. 86) states that “peer support groups can help because peers can often clarify colleagues’ insights, listen for and correct cognitive distortions, offer perspective/reframing, and relate to the emotional state of the social worker”. Team-based interventions to address STS also serve to highlight shared experiences while normalizing reactions, and can increase team cohesion (Catherall, 1995).

The literature clearly demonstrates that no single STS intervention has conclusive empirical support to reduce STS over time. However, key components of promising interventions have been identified to show improvements in symptoms. These key elements include trauma-informed care training, psychoeducation around trauma and trauma reactions, mindfulness, regular practice of self-care, identifying rewards of the

work, and supervisor and peer support. The research also highlights the limitations of brief or short-term interventions as well as interventions that are provided offsite. The research indicates the need for an integrated, trauma-informed, organizationally-embedded, and ongoing intervention to address the very pervasive impact of secondary trauma. What follows is a description of one such model, the Stress-Less Initiative (Vega, 2017), which embeds organizational trauma training and education, increased peer and supervisory support, effective relaxation and coping strategies directly into the model and provides guidelines for on-site implementation.

CHAPTER 5: Stress-Less Initiative Group Model

Origins of the Stress-Less Initiative

The Stress-Less Initiative (Vega, 2017) was designed to reduce secondary traumatic stress among frontline violence intervention workers. The proposed model arose from an unmet need to “help our helpers”. It was established in Philadelphia at a hospital-based Violence Intervention Program for community intervention workers providing intensive case management service and trauma-focused therapy to children and families after a violent assault.

Supervisors often observe behavioral changes in staff and trainees who may be unprepared to address their own self-care needs in the face of emotionally challenging work with clients. While efforts to address these needs in individual supervision are imperative, a trauma-informed group model provides an opportunity to learn, process, and share experiences among colleagues in a supportive atmosphere.

As a Clinical Supervisor of a Violence Intervention Program, this author received multiple reports from staff regarding their individual trauma reactions to their work. Some staff reported nightmares, trouble sleeping, hyperarousal symptoms, and often had feelings of helplessness due to systemic barriers impacting their work. As much as these trauma reactions were addressed through individual reflective supervision, this author felt limited by the competing case management needs for clients and administrative demands. The Stress-Less Initiative (Vega, 2017) was fueled by the belief that staff health and wellness deserved its own space, and that the collective support, guidance, and validation from coworkers can serve to mitigate the effects of STS and the inherent systemic challenges of violence intervention work.

Often, violence intervention workers learn about secondary traumatic stress through training, but they may not recognize the personal symptoms or how to address them in order to prevent short and long-term effects. The Stress-Less Initiative (Vega, 2017) aims to build workers' awareness of these symptoms and provides coping strategies to increase positive health related behaviors. The model provides a safe space for sharing the ways in which engaging in intensive trauma work affects individuals' thoughts, feelings, behaviors, and physical health, while receiving social support, encouragement, and guidance from other team members on a continual basis.

Development of the Stress-Less Initiative

From the extensive review of literature described above, research on causes, risk and protective factors, and effective intervention components were translated into the development of the Stress-Less Initiative (Vega, 2017) intervention to prevent STS. Using program theory to describe the intervention's key targeted outcomes (long-term goals), behavioral objectives (risk and protective factors), and target constructs (knowledge, beliefs, and skills that increase completion of objectives) guided the development of the intervention content (Winston & Jacobson, 2010; Marsac, Hildenbrand, Kohser, March, Kenardy, & Kassam-Adams, 2015). This systematic, evidence-based approach to intervention development is grounded in behavioral science theory and uses features of established models for health promotion and disease prevention (Marsac et al., 2015; Winston & Jacobson, 2010).

Following the guidelines of Winston & Jacobson (2010), a program theory model was developed to illustrate this author's conceptualization of the hypothesized

mechanisms linking the intervention's components to the overarching goals (see Figure 1). The key outcomes of the intervention are a) to prevent/reduce STS among violence intervention workers and b) to increase/promote positive health related behaviors. To meet these goals, the author defined the behavioral objectives based on the risk and protective factors and the target constructs (stress, STS, compassion satisfaction, empathy, personal trauma history, peer and supervisor support, and adaptive coping). Finally, the target constructs informed the development of the Stress-Less Initiative (Vega, 2017) intervention components (screening and assessment, learning principles, processing component, and skill-building activities).

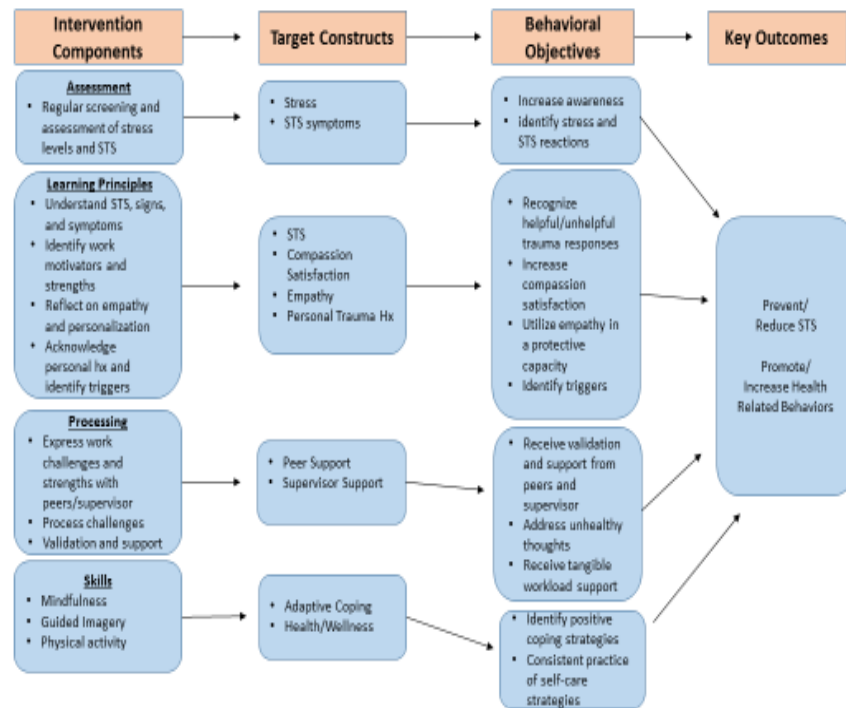


Figure 1. Program Theory Model applied to the development of the Stress-Less Initiative Intervention.

Stress-Less Initiative Key Assumptions

Peer Support and Resilience

Increasing social support for trauma workers has been an underutilized resource in many organizations to reduce STS (MacRitchie & Leibowitz, 2010). Traditionally resilience has been defined to focus on an individual's strengths. However, this model asserts that while there are individual factors that can increase one's resilience, there exist relational and contextual factors that can increase individual and group resilience. Due to the nature of this work, mutual goals, shared experiences and knowledge, the strength of the group is an extremely powerful intervention. This group model targets both the primary and secondary appraisals and its goal is that increasing the availability, quantity, and quality of supervisor, peer, and organizational support will change the appraisal of stress and response, ultimately decreasing STS.

While the Stress-Less Initiative (Vega, 2017) emphasizes peer support and mutual aid, the addition of supervisor support serves to reduce or alleviate concrete work stressors and/or workload. Ideally, the supervisor becomes a buffer to address the organizational and systemic factors that are increasing stress reactions (by diversifying tasks, reducing caseload, halting intakes, permitting time off, escalating client or organizational concerns, providing encouragement and recognition, etc.). The supervisor's role is to advocate for staff wellness (balancing that with client safety and needs) and think through creative solutions to mitigate the systemic sources of stress. Many of these organizational resolutions are often temporarily enacted to give staff enough time and space to effectively cope. The decision to include the supervisor in the

intervention also promotes increased empathy for staff which should serve to increase support to workers.

In addition, workers may not always know how to navigate a personal crisis or situation in which they are experiencing high levels of secondary traumatic stress. They may not be able to identify and utilize resources they need to feel better and cope effectively. For these reasons, it is recommended that the group intervention is facilitated by a Clinical Supervisor who is more removed from the intensive trauma work, who can support workers through their experience and help create a safe culture where staff are able to utilize resources and support.

Power and Control

As cited in the literature, lack of internal control is part of the trauma experience (Herman, 1992). Interventions that target STS should incorporate elements to address the structural and systematic limitations of the work and work environment. Even though it is recommended that the group model be facilitated by a supervisor, the intervention is designed to reduce power differentials, and the supervisor is an active participant in the group. Additionally, some violence intervention workers can feel a lack of power working with trauma victims when systems do not protect their clients or further marginalize them. There can exist a parallel lack of power within the organization, in which workers do not have control over many elements that affect their workload or that can reduce their stress. These elements can include caseload size, type and quality of supervision, administrative policies regarding vacation time, and safety. Interventions to effectively address STS need to incorporate elements that allow workers to express issues

related to power and control and find solutions to give workers more voice and choice over their work, health, and wellbeing while reducing hierarchical constructs of power within organizations.

False Dichotomy between Personal and Professional

In Shulman's book, *The Skills of Helping* (2006), he argues that we are at our best in our work when we are able to integrate our personal self into our professional role. However, in the social services field workers are often trained to keep their professional self separate from their personal self to avoid the emotional impact of this work. We come into this work with our own histories, cultures, values and beliefs, and these factors determine how we relate to clients. Relational theory suggests that all of our interactions with clients are impacted by our own beliefs, values, and experiences. When we use empathic connection with our clients, our use of empathy permits bidirectional impact. We affect our clients and our clients affect us. This is what permits workers to feel both the challenges of this work and the great rewards of this work. By acknowledging our own histories and addressing our own challenges, we can be more resilient and effective with our clients. Especially in trauma work, there needs to be an emphasis on encouraging workers with their own unresolved trauma histories to prioritize their own recovery.

“The self-reflection of the therapist is more than quiet contemplation. It is rigorous, a deliberate searching within oneself for what one feels and does, motivations, impulses, expectations of self and others, beliefs, and worldviews. It is knowing and defusing one's own psychological landmines, creating safety and stability within oneself (Danylchuk, 2015, p. 4)”.

The Stress-Less Initiative (Vega, 2017) includes strategies to address individual triggers and to reflect on how our own experiences impact our work with clients, and how our work with clients impact who we are both personally and professionally.

Stress-Less Initiative Overview

The Stress-Less Initiative (Vega, 2017) is a strengths-based model aimed at increasing individual and group resilience while providing a safe space for staff and trainees to share how violence intervention work affects them personally and professionally. Groups offer a semi-structured format to provide validation and support to one another, to celebrate the rewards of this work and to have a place to process the challenges. The group is ongoing and embedded within the organization which allows for early identification of STS symptoms and increased accessibility and utilization of support and coping strategies.

Stress-Less Initiative (Vega, 2017) is a 12 session group model that includes psycho-education, screening and assessment for STS, learning and reflection activities targeted to increase protective factors (while reducing risk factors), processing of work challenges and rewards, and coping skills to build resilience. It is recommended that the group be facilitated by a Clinical Supervisor, in order to increase the supervisor's empathy with staff experiences, and to enable the supervisor to implement organizational interventions (changes in case assignment, advocate to administration, diversify roles, halting intakes, teamwork, etc.) to reduce stress. Sessions occur once a month, and each session is 90 minutes. The recommended group size is 6-8 participants, ideally not to exceed more than 10 participants per group. Each session is dedicated to a learning principle, and

includes an assessment, learning component, processing, and skill- all centered on building strength and resilience. Table 1. illustrates session-specific assessment, learning principles, skills, and targeted constructs.

Session Breakdown and Process

Each group is broken into four components: assessment; learning; process; and skill. Assessment begins with a brief self-reflective awareness exercise in which participants reflect on their physical body reactions, cognitions, feelings, and behaviors and rate their stress level using the Stress-Less Initiative visual stress scale (Vega & Menapace, 2017).

Please refer to Appendix B for Stress Scale. Each session, participants rate their stress level and during sessions 2, 5, 8, and 12, they complete the Professional Quality of Life Scale (Hudnall Stamm, 2009) on the Provider Resilience mobile phone application (app). A recent pilot

A: Assessment
L: Learning
P: Process
S: Skill

study has shown that regular use of the Provider Resilience Mobile Application significantly decreased both burnout and compassion fatigue among mental health care providers (Wood et al., 2016). The use of the phone application is for participants' own personal reference and understanding of their levels of STS, burnout, and compassion satisfaction and to increase regular assessment and screening. There is evidence to support the importance of regular screening and assessment for reducing stress and trauma reactions (Cohen, Mannarino, & Deblinger, 2006). Group members continue by sharing their high and low of the past week with colleagues.

The learning and reflection component introduces learning principles and encourages a discussion from participants about how these concepts relate to their direct

work with clients. These concepts were identified in the literature as targeted constructs and include: psychoeducation, empathy, compassion satisfaction, power and control, boundaries, cognitive reframing, mindfulness, and social support. Participants are encouraged to share their knowledge and reflect on their own experiences. These principles are used to determine what level of knowledge participants have, and also how that knowledge and skills are applied in practice with clients. This portion of the session allows for open and honest dialogue about some of the challenges in delivering services to marginalized clients. The goal is to create an adult learning environment where participants share their expertise and experiences with the group to increase engagement and translational learning.

The processing component is an opportunity to address individual strengths, challenges, and work victories. During this part of the group session, participants are encouraged to support one another, highlight successes, and process challenges. There is strong emphasis on talking not just about barriers to case goals, but also about how those barriers affect us individually (thoughts, feelings, body reactions, and behaviors). This reflection is very important to reduce STS as workers can hear, witness, and experience many challenging and emotionally draining situations in a given day, and due to the fast-paced nature of the work, these details often get lost or buried. Literature supports the need for dedicated time to process and create a context for these experiences. Having a personal trauma history was identified as a significant risk factor for STS, so it is even more important for individuals to have dedicated time to identify potential triggers and understand the relationship between past experiences, current trauma exposure, and overall health and wellness.

Lastly, team members share responsibility for introducing new self-care skills to the group, practice together, and encourage one another to regularly practice individual skills in an effort to reduce stress symptoms. Participants rotate introducing the skills, which allows participants to increase their autonomy about what works for them, while not being told what skills they need to use. Everyone is unique so they are encouraged to utilize the skills that are working for them, while also getting exposure to new skills they may not have tried before. Each session ends with participants verbalizing the three skills that they are committed to practicing until the next group session. Please refer to Appendix A for the Stress-Less Initiative (Vega, 2017) treatment manual which describes in detail the specific design, session content, and implementation guidelines.

Sessions	Learning Principles	Assessing Stress Levels	Processing	Skills (examples)	Targeted Constructs
1	Group Resilience	Stress Thermometer	Peer led discussion	Mindfulness	Peer Support; supervisor support; adaptive coping
2	Understanding Stress	Stress Thermometer; Provider Resilience App	Peer led discussion	Deep Breathing	Stress, STS symptoms, peer support, supervisor support; adaptive coping
3	Our Journey-self reflection	Stress Thermometer	Peer led discussion	Progressive Muscle Relaxation	STS symptoms, personal trauma hx, peer support, supervisor support; adaptive coping
4	Power and Control	Stress Thermometer	Peer led discussion	HeadSpace	STS symptoms, peer support, supervisor support; adaptive coping
5	Empathy	Stress Thermometer; Provider Resilience App	Peer led discussion	Guided Imagery	Empathy, STS symptoms, compassion satisfaction, peer support, supervisor support, adaptive coping

6	Plan for Resilience	Stress Thermometer	Peer led discussion	Music	Stress, STS symptoms, peer support, supervisor support; adaptive coping
7	Acknowledging Rewards and Challenges	Stress Thermometer	Peer led discussion	Self-Compassion	Peer support, compassion satisfaction, supervisor support, adaptive coping
8	The U in Trauma	Stress Thermometer; Provider Resilience App	Peer led discussion	Letting Go	Personal Trauma History; STS symptoms, peer support, supervisor support, adaptive coping
9	Stay the course	Stress Thermometer	Peer led discussion	Self-Reflection	Stress, STS symptoms, peer support, supervisor support, adaptive coping
10	How do we measure success	Stress Thermometer	Peer led discussion	Yoga	STS symptoms, compassion satisfaction; peer support, supervisor support, adaptive coping
11	Mind Full	Stress Thermometer	Peer led discussion	Humor	Stress, STS symptoms, peer support, supervisor support, adaptive coping
12	Work-Life Balance	Stress Thermometer; Provider Resilience App	Peer led discussion	Meditation	Stress, STS symptoms, compassion satisfaction, peer support, supervisor support, adaptive coping

Table 1: Stress-Less Initiative Session Components

The Stress-Less Initiative (Vega, 2017) is an integrative model that targets multiple levels of risk and protective factors for STS, including the individual, interpersonal, and organizational levels. When individuals experience increased levels of stress, research shows that both utilization of social support and utilization of self-care

strategies decrease; both essential factors in reducing stress. The Stress-Less Initiative (Vega, 2017) promotes peer, supervisor, and organizational support to mitigate the impact of trauma exposure. It is informed by research on the risk and protective factors and grounded in program theory. It is the only known team-based, organizationally-embedded, and ongoing model developed to address STS. Effective application of the model includes an agency needs assessment, training, adherence to the Stress-Less Initiative (Vega, 2017) Intervention Manual and Implementation PowerPoint Tool to increase efficacy in implementation and replicability. In the next chapter, recommendations for effective implementation are provided.

CHAPTER 6: Implementation

The Stress-Less Initiative (Vega, 2017) Intervention Manual provides a learning and reference guide for administrative leaders and facilitators on how to implement the intervention. The primary purpose of the manual is as a guide to in-person training provided by the intervention developer. The training is followed by a period of regular consultation by the developer in order to support successful implementation and address any barriers or challenges. This intervention is intended for workers employed in organizations providing direct services to individuals exposed to trauma.

The Stress-Less Initiative (Vega, 2017) Intervention Manual is organized into two sections. The first section provides an introduction for facilitators which includes goals of the model and guidelines for implementation. The guidelines for implementation include recommendations regarding facilitation, eligibility, schedule of session, confidentiality, and session components. The second part of the manual details the protocol for all 12 standard sessions. Appendices to the manual include the Stress-Less Initiative© Stress Scale (Vega & Menapace, 2017), session handouts, a fidelity tool, and sample pre/post measures for evaluation of the intervention. The Stress-Less Initiative manual and materials have a copyright by the Children's Hospital of Philadelphia (2017).

Key Strategies for Effective Implementation

Below are recommendations to assist in successful implementation of the model:

Facilitation

- It is recommended that the facilitator hold a Master's Degree in Social Work or related counseling field. Ideally, the facilitator should be the frontline supervisor/manager or hold a clinical position with which frontline workers

have regular and consistent contact, and should be easily accessible in case of a potential crisis.

- Facilitator needs to have extensive training in trauma informed care, extensive knowledge of trauma symptoms and implications for clinical practice.
- Facilitator should have skills in building consensus and mediating conflicts.
- Facilitator needs to have respect for frontline workers' experiences and a genuine understanding of how STS can negatively impair workers and affect clients.
- Facilitator needs to be able to advocate for workers and balance the overall program needs with trauma-informed solutions that ensure the health and wellness of staff and clients.
- For groups with a high degree of identified interpersonal conflict, co-facilitation is recommended.
- Group is contra-indicated for any staff in which their safety cannot be ensured.

Eligibility

- Sessions are strongly encouraged for all frontline and clinical staff who have direct contact with clients/patients. Other staff may also benefit from the Stress-Less Initiative and the decision to include other staff will be at the discretion of the Administrative leaders and facilitator.

Schedule of Sessions

- Sessions should be held on a monthly basis. The timing of sessions should be scheduled at a time that ensures the least amount of work-related conflicts for staff.
- Each session is 90 minutes long.
- At the facilitator's discretion, the Plan of Resilience Session (Session 6) can be implemented at any time there is a potentially traumatic event for staff, the organization, or the community.

Confidentiality

- Facilitator must maintain confidentiality at all times, and stress the importance of confidentiality within the group. Exceptions to confidentiality include: if someone discloses information that falls under state Mandatory Reporting Law, or if a participant has intentions to harm themselves or others.
- Trust and confidentiality are crucial to ensure that participants feel safe enough to share such vulnerable information. For this reason, it is not recommended to have more than 10 participants (excluding facilitator) in any one group session.

- Although the group intervention aims to focus sessions directly on secondary traumatic stress reactions, there are times when participants may express concerns regarding organizational factors or work strain that contribute to this stress. Exceptions to confidentiality are warranted with permission from participants to escalate organizational concerns to the administrative team.

Administrative Buy-in and Support

- Agency leadership plays a critical role in providing the necessary tools for staff to successfully navigate their job responsibilities. Agency leadership must be educated to the effects of STS on their workforce, provided with tools to effectively address STS, and allocate external and internal resources to address it.
- Prior to any implementation consideration, this author will meet with agency decision makers to discuss level of interest, agency readiness, feasibility, and commitment. Agency leadership will be provided a high-level overview of the intervention, including strategies for implementation, on-going consultation, and follow up. Research supporting the need for this intervention will be provided to the administrative leaders.
- Once it is determined that the agency is interested, key stakeholders will meet with their administrative team to discuss the impact of STS on overall services to clients, costs to the organization, and the health and wellness of staff. Focusing on the potential benefits of the model (improvements in quality care, increased job satisfaction, team cohesion, work longevity, reduced absences, etc.) can aid administrators to understand and support the need for the intervention. Administrative support for the model is critical as the intervention may require some flexibility in agency policy and procedures.
- In addition to administrative buy-in, it is important for staff to have a voice in whether the intervention is something they think would be helpful and if they want to participate in it.

Trauma-Informed Organizational Assessment

- Prior to implementation, it is recommended that an organization complete the Agency Self-Assessment for Trauma-Informed Care (The Trauma Informed Care Project, 2010). This is intended to be a tool that will help assess the organization's readiness to implement a trauma-informed approach. The assessment has five domains (supporting staff development, creating a safe and supportive environment, assessing and planning services, involving consumers, and adapting policies). In order for the intervention to be effective, there has to be a level of organizational stability and willingness to create a safe and trauma-informed culture.

Training and Consultation

- Prior to implementation of the model there is a four-hour training and it is recommended for all staff and leadership to attend. All levels of an organization can be impacted by STS, so it is important for the entire organization to understand the impact of trauma, know the signs and symptoms of STS, and learn about the model.
- The four hour training consists of one hour dedicated to trauma-informed care training, one hour focusing on understanding STS as an organizational issue, thirty minutes on the development and session components of the model, sixty minutes involve a demonstration of a group session where staff are asked to participate and share their experiences, and the last thirty minutes focus on processing and questions.
- After training is completed, facilitators will receive the Stress-Less Initiative (Vega, 2017) Intervention Manual and the Implementation PowerPoint Tool to learn (Please see Appendix C) specific session content and goals.
- Eight consultation calls are recommended with intervention developer to discuss implementation strategies and problem solve potential barriers. Calls should occur in months 1, 2, 3, 4, 6, 8, 10, 12.

Fidelity with Flexibility

- While it is important to ensure fidelity to the model, some flexibility is permitted. As with any group intervention, there should be some adaptability to fit different community and group contexts. In addition, facilitators should allow flexibility in sessions to optimize the adult learning structure.

Evaluation

- While the Stress-Less Initiative (Vega, 2017) has not yet been subject to rigorous empirical validation, future efforts to evaluate its effectiveness at reducing STS and to examine other potential outcomes including job satisfaction, employee engagement, perceived peer support, perceived supervisor support, perceived stress, compassion satisfaction, and burnout are critical.
- It is recommended that group participants and facilitators complete baseline measures, 6 month measures, and post intervention measures to evaluate effectiveness at reducing STS and relationships with other outcome measures. Please refer to recommended measures in Table 2. Pre/Post- test outcome surveys are included in Appendix E.

Variables	Scale Used	# of Items	Source
Secondary Traumatic Stress	Professional Quality of Life Scale (ProQOL)	30	Hudnall Stamm, 2009
Stress	Perceived Stress Scale	10	Cohen, Kamarck, and Mermelstein, 1983
Organizational Support	Perceived Organizational Support	8	University of Delaware, 1984
Supervisor Support	Perceived Supervisor Support	8	University of Delaware, 1984
Coworker Support	Psychosocial and Lifestyle Questionnaire	3	Smith, Fisher, Ryan, Clark, and Weir, 2006-2010
Job Satisfaction	Job Satisfaction Scale	36	Spector, 1994

Table 2: Stress-Less Initiative Outcome Measures

CHAPTER 7: Discussion

Violence intervention workers are at an increased risk for STS (Bell, 2003) which can take a toll on workers' emotional and physical health (Beaton & Murphy, 1995; Bell, 2003; Figley, 1995; Pearlman & Saakvitne, 1995). This dissertation described the strong evidence as to the harmful consequences of unmitigated STS on individual workers, their clients, and organizations (Bell, 2003; Bercier & Maynard, 2015; Figley, 1995; Pearlman & Saakvitne, 1995). The purpose of this dissertation was to conduct a literature review of the risk and protective factors of STS as well as the strengths and limitations of the current STS interventions. This body of research informed the development of the Stress-Less Initiative (Vega, 2017), an innovative group model grounded in program theory, which focuses on increasing social support (peer, supervisor, and organizational) to prevent and mitigate the impact of trauma exposure on violence intervention workers and promote positive health related behaviors.

The Social Ecological Model (SEM), the Transactional Model of Stress and Coping (TMSC), and the Buffering Hypothesis were presented to describe the complex and dynamic relationship between internal and external factors and individuals' responses to secondary traumatic stress. The SEM was applied to understand secondary trauma with particular emphasis on the external and institutional factors that may increase susceptibility. Thus far, interventions focus narrowly on self-care strategies and place the onus on individual workers to resolve a systemic issue. Current research endorses STS as a systemic issue, but interventions have yet to target these systemic causes (Bell, Kulkarni, & Dalton, 2003; Bloom, 2013; Bober & Regehr, 2006; Killian, 2008).

The TMSC and the Buffering Hypothesis demonstrate the powerful effect of social support in moderating the pathological outcomes of stress. Social support can interrupt the development of illness by targeting an individual's primary appraisal. Perceived social support can alter the perception of a stressor if an individual believes he or she has the available social resources to cope (Lazarus & Cohen, 1977). Social support can also mediate the negative impact of stress by reducing or eliminating the stress reaction or by directly influencing physiological outcomes (Cohen & Wills, 1985). Together with the SEM, these theories highlight the need for organizational interventions that focus on enhancing social support to prevent and reduce STS for violence intervention workers.

From the review of literature, key risk and protective factors were identified and integrated as target constructs in the design of the intervention. Having a personal trauma history, increased empathy, and caseload size, especially the number of trauma cases on one's caseload, were all identified as significant risk factors. Protective factors include; trauma training and education, peer support, supervisor support, mindfulness, and adaptive coping (NCTSN, 2018; Shauban & Frazier, Dalton, 2001). While a large body of research on the impact, risk and protective factors for STS exists, minimal research has been undertaken to develop, test, and refine effective interventions.

Due to methodological deficiencies in existing STS interventions, it is difficult to infer causality of positive outcomes in many studies. However, some promising interventions have emerged to address STS. Currently, the gold standard in STS prevention is self-care, but available research has provided weak evidence for a relationship between time spent engaging in self-care activities and traumatic stress

scores (Bober & Regehr, 2006, Killian, 2008). Despite widespread recommendations for workers to engage in self-care practices to mitigate the negative impact of working with individuals exposed to trauma, self-care alone may not be enough. Organizations need to take greater responsibility for identifying and addressing secondary trauma reaction in staff as many organizational correlates have been identified that increase risk. From what we now know regarding the effects of trauma exposure, organizations have a greater responsibility to employees to ensure their health and wellness. Additionally, empirical support suggests that trauma-informed care training increases compassion satisfaction (Sprang, Clark, & Whitt-Woosley, 2007), which may buffer the effects of STS. Lastly, strengths-based approaches are helpful in encouraging workers to identify the rewards of their work and find meaning in their experiences, further permitting staff the space and time to reflect and process their challenges and their successes (Shew, 2010).

Individual therapy has shown some benefits to reduce stress reactions, but may be costly, require time outside of work, and also may increase the stigma around secondary trauma. In addition to the limitations of individual therapy, many STS interventions are brief and do not address the chronicity of workers' trauma exposure. Throughout the literature, the most robust finding was the power of group support to reduce STS symptoms. Group support reduces stigma, normalizes STS reactions, provides emotional support, identifies colleagues' cognitive distortions, provides validation, identifies shared experiences, and builds team cohesion (Aycock & Boyle, 2009; Catherall, 1995; Houck, 2014). An organizationally embedded group intervention model provides many benefits to address workers' secondary trauma reactions among peers who understand and validate their experiences.

Based on existing evidence and an understanding of STS, the Stress-Less Initiative (Vega, 2017) was developed. This model integrates individual, interpersonal and organizational components to reduce secondary trauma. In addition to addressing individual and interpersonal needs within the group, a key component is the Clinical Supervisor's (facilitator) responsibility for identifying and implementing organizational support to decrease stress and trauma exposure, such as diversifying tasks, reducing caseloads, halting intakes, providing time off, escalating client or organizational concerns, providing encouragement, and positive recognition. The combination of individual, interpersonal, and organizational support provides a potent method for addressing this complex and multifaceted issue.

Finally, a chapter on the recommendations for implementation were discussed, with a special focus on the need for administrative buy-in and support. Administrative leaders must understand not just the impact of STS on individual employees, but the impact on the quality of services provided to clients, the overall fiscal costs to the organization, and the effects to the culture and climate of the work environment. As a result, organizations providing trauma services have an ethical responsibility to address this risk among their employees.

Implications for Research

Currently limited evidence exists describing effective interventions to reduce symptoms of STS and even sparser information is available regarding the outcomes of such interventions. Bercier's (2013) comprehensive systemic review and meta-analysis on the outcomes of current STS interventions found only two single group, pre-posttest studies that met the inclusion criteria. From the available research that exists we know

that STS remains a significant problem, impacts workers, their clients, and organizations, there are limited interventions that address organizational factors, and of the intervention studies that do exist there is poor evaluation/design that limits the ability to say what works in the area of STS prevention/treatment. There is a strong call to action for additional research in this area.

As the understanding of the negative sequela of trauma has rapidly advanced in the last 20 years, the damaging impact of trauma exposure on individual workers has become clear. While the Stress-Less Initiative has not yet been subject to rigorous empirical validation, future efforts to evaluate the Stress-Less Initiative's effectiveness at reducing STS and to examine other potential outcomes including job satisfaction, employee engagement, perceived peer support, perceived supervisor support, perceived stress, compassion satisfaction, and burnout are critical. While randomized control trials of STS interventions may be premature or challenging due to barriers of sample sizes and recruiting and retaining participants, researchers could advance the field by conducting smaller scale, between group studies in a more rigorous manner. In addition to using quantitative methods, qualitative methods can provide a deeper understanding of workers' experiences, perception of need for intervention; likeability of intervention; availability and utilization of resources.

In addition to effectiveness studies, gaining a better understanding of what components of the intervention produce or fail to produce which outcomes is critical. This knowledge will permit agencies to apply these methods more strategically, cost effectively, and reach a greater number of individuals. The provision of additional

research will advance our efforts to address the impact of STS and also provide important recommendations for agency policies and practices.

Implications for Policy

Many STS researchers have recommended changes to current organizational policies to protect workers (Rosenbloom, Pratt, & Pearlman, 1999; Bell, 2003; Boeber & Regegr, 2006) from the impact of STS. Special attention must focus on increasing availability of trauma informed care training across social service sectors. The understanding of the impact of trauma on both workers and clients should to be integrated into agencies' policies and practices.

Secondary trauma is a natural occurrence due to the high emotional demands inherent in violence intervention work. Often, secondary trauma reactions are misconstrued by supervisors as performance-based issues, and punitive measures are enacted instead of increasing supportive resources. This response isolates workers and many workers leave the field prematurely. Implementation of policies to address STS in workers by mandating the use of reflective supervision, increasing trauma training and education, implementing flexible vacation and sick hours; reducing caseload sizes, and provision of organizationally embedded STS interventions by serve to reduce the negative outcomes associated with STS. Apart from improving the health and well-being of employees, such policies would ultimately increase the quality of services provided to clients.

Implications for Practice

Among the protective variables, having higher levels of social support is significantly related to lower levels of STS (Bride et al., 2007; Townsend, 2005). In

supportive employment environments, workers can talk about their experiences and symptoms with colleagues and obtain emotional support (Townsend, 2005). Well-established support systems within organizations provide workers easier access to more resources to prevent or cope with STS reactions. Implementation of a group intervention, such as the Stress-Less Initiative (Vega, 2017), sends a clear message to employees that the organization cares about their health and wellness. In addition, having the intervention provided in an ongoing fashion (versus a one-time session) and embedded within the organization, acknowledges that STS is a natural outcome of doing trauma work (Figley, 1995; Pearlman & Saakvitne, 1995). This alone dramatically reduces the stigma involved in accessing support, which is among the greatest barriers to effective STS interventions.

Another important consideration for practice is the understanding that workers with their own personal trauma history are at greater risk for STS. It has been established that individuals in social services professions may experience greater levels of personal trauma (Choi, 2011; Esaki & Larkin, 2013; Jenkins & Baird, 2002). Administrators and supervisors must incorporate this understanding into their reflective supervision practices, and encourage recovery and support to address unresolved trauma in workers. Providing this level of support to workers is especially important as unresolved trauma can directly impact quality of services provided to clients, and has the potential to create re-traumatization for workers and their clients. An ongoing, onsite, systems-based model like the Stress-Less Initiative (Vega, 2017) creates a safe space and incorporates content to have workers reflect on their own history, values, beliefs, triggers, and strengths they bring to their work with clients.

Research evidence clearly documents that STS is a major systems issue for which there remains a lack of organizational interventions. While the primary focus of this research was in the violence intervention sector, The Stress-Less Initiative (Vega, 2017) would likely be applicable across different settings and disciplines. STS is a prevalent occupational threat not just among violence intervention workers, but among all professionals dealing with populations exposed to trauma. There is a greater call to action across different systems of care to implement interventions to address this issue. Juvenile detention staff, probation officers, child welfare workers, behavioral health providers, gang intervention workers, teachers, school staff, judges, district attorneys, drug and alcohol providers, police officers, physicians, nurses, ancillary staff, and researchers are all exposed to the impact of trauma and require the education, training, and support to address it.

Conclusion

Identification of STS as a systemic issue encourages those in the profession to reexamine the relationship between trauma and this type of employment stress. Evidence demonstrates the need for administrators and managers to implement organizational responses, such as reducing workloads, diversifying tasks, and increasing vacation or sick time to address employee health and safety. Other organizational responses, such as ongoing peer support, increased supervision, and creating a culture that acknowledges the potential for STS can serve to prevent or decrease symptoms.

Given that individual-level responses to address STS have demonstrated limited effectiveness and evidence to suggest that organizational factors contribute to STS, any

intervention intended to reduce the effects of STS should optimally be embedded within the organization. Strategies incorporated into the structure of the organization help to reduce the stigma in accessing support and will most likely increase utilization by staff. In addition to making staff health and wellness a priority, organizations have an obligation to provide quality care to the clients and families who depend on providers for their own safety, support, and resources.

The Stress-Less Initiative (Vega, 2017) is a promising intervention that was developed by integrating evidence-based components and program theory into a model aimed at increasing protective factors and reducing risk for STS. The Stress-Less Initiative (Vega, 2017) increases peer, supervisor, and organizational support to address trauma symptoms, and promote positive health related behaviors. This organizational response is likely to lead to a healthier environment for workers, ultimately improving the well-being of service professionals and enhancing their ability to provide quality care to clients.

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Stress-Less Initiative©: A Trauma-Informed Group Model to Reduce Secondary Traumatic Stress



Facilitator Manual

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I. Goals of the Model

1. Early identification of Secondary Traumatic Stress (STS), Vicarious Trauma (VT), and Burnout (BO)
2. To increase awareness of our own thoughts, feelings, behaviors, and physical manifestations of stress
3. To increase trust and safety among the team
4. To encourage proactive organizational support
5. To normalize and validate STS symptoms and remove the stigma that having symptoms reflects an individual deficit
6. To learn protective approaches to engage in trauma work, as well as, skills to reduce stress
7. To build cohesion and unity among team members, acknowledging that we are not holding the impact of this work alone
8. To identify opportunities for growth through discussion and sharing of positive experiences

II. Guidelines for Implementation

☐ **Facilitation**

- It is recommended that the facilitator hold a Master's Degree in Social Work or related counseling field. Ideally, the facilitator should be the frontline supervisor/manager or hold a clinical position in which frontline workers have regular and consistent contact with, and is easily accessible in case of a potential crisis.
- Facilitator should have extensive training in trauma informed care, extensive knowledge of trauma symptoms, and implications for clinical practice.
- Facilitator should have respect for frontline workers experiences and a genuine understanding of how STS can negatively impair workers and affect clients.
- Facilitator should be able to advocate for workers and balance the overall program needs with trauma-informed solutions that ensure the health and wellness of staff and clients.

☐ **Eligibility**

- Participation is strongly encouraged for all frontline and clinical staff who have direct contact with clients/patients. Other staff may also benefit from Stress-Less Initiative and the decision to include other staff will be at the discretion of the facilitator.

☐ **Schedule of Sessions**

- Sessions should occur on a monthly basis, and no less frequently than monthly sessions are recommended. The timing of sessions should be scheduled at a time that ensures the least amount of work-related conflicts for staff.

- Each session is 90 minutes long.
- At the facilitator’s discretion, the Plan of Resilience Session (Session 6) can be implemented at any time there is a potentially traumatic event for staff, the organization, or the community.

☐ Confidentiality

- Facilitator should maintain confidentiality at all times, and stress the importance of confidentiality within the group. Exceptions to confidentiality include: if someone discloses information that falls under their state’s Mandated Reporter Law, or if a participant has intentions to harm themselves or others.
- Trust and confidentiality are crucial to ensure that participants feel safe to share vulnerable information. For this reason, it is not recommended to have more than 10 participants (excluding facilitator) in any one group session.

☐ Session Breakdown

- Each group is broken into 4 components: assessment; learning; process; and skill. Assessment begins with a brief mindfulness exercise in which participants reflect on their body and symptoms and rate their stress level using a stress scale.
- The learning component introduces concepts and practice strategies on how to engage in trauma work while increasing resilience.
- The processing component is an opportunity to address individual strengths, challenges, and resilience. The team discusses the material presented and how it relates to them and to the work of the program. Stress-Less Initiative creates a safe space for sharing the ways in which trauma work affects individuals’ thoughts, feelings, behaviors, and physical health, while receiving support, encouragement, and advice from other team members.
- Lastly, team members share responsibility for introducing new self-care skills to the group and encourage one another to regularly practice these skills in an effort to address STS symptoms, VT and BO. Example activities have included: mindfulness, office yoga, guided imagery, adult coloring, Ted Talks on resilience, music, exercise, developing a “Self -Love menu,” and exercising.

<p>A: Assessment</p> <p>L: Learning</p> <p>P: Process</p> <p>S: Skill</p>

Session 1: Group Resilience

Materials: *“Supporting Resilience” (youtube), Stress Scale, *Headspace Application; Power Point; A/V with projector; Lightning VGA Adapter (optional)

☐ **Introduce Stress-Less Initiative Model**

Facilitator:

- Shares that too often the very emotional details of this work can get lost in individual supervision with the hustle and bustle of our work, but each one of your personal health and wellness are very important to me and I hope that through this time together we can build more trust and be a source of support for one another
- (PP) This is your group so come and relax, share, and have special time just to focus on you!
- Leads an interactive discussion about the goals of the group:
 - Early identification of STS, VT, and BO
 - To increase awareness of our thoughts, feelings, behaviors and physical manifestations of stress
 - To increase trust, safety, and cohesion among team members
 - To encourage proactive organizational support
 - To normalize and validate secondary traumatic stress symptoms and remove stigma of disclosure
 - Learn approaches to reduce stress associated with providing trauma informed services
 - To acknowledge and celebrate the growth opportunities and rewards in this work
- Leads an interactive discussion about the rules of the group:
 - Stress the importance of confidentiality with facilitator and with other participants
 - The facilitator will **NOT** share any personal information with administration unless prior permission from a member is given to arrange special accommodations or a wellness plan.
 - What is shared in group stays in group (unless it violates reporting laws regarding both clients and staff). Please check your individual state’s laws. Be explicit about what this means
 - Anything that is shared that is especially concerning regarding an individual member, facilitator will work with member individually and mutually to plan and refer for additional support as needed.

Facilitator: describes the breakdown of each group session

Assessment: Each group session will begin with a check-in. We begin with a mindfulness activity to increase awareness of stress reactions and we share with the group where we are on the visual stress scale from 1-10 and then share our high and low of the week. This will help us to build awareness of our own stress levels, and our coworkers.

Learning: Facilitator will share a learning or professional development strategy that may be helpful in engaging in trauma work.

Process: Each member is encouraged to express any stressful cases or situations that are affecting them. We will pay special attention to changes in thoughts, feelings, behaviors, and body symptoms. We will provide validation and support to one another. Members are also encouraged to share any successes they have had in this work with the group or ways that they have been able to overcome similar challenges.

Skill: Each session, a member will rotate introducing a new coping skill to the group. We will practice this skill together as a group and add it to our list of self-care strategies. This will allow us to get exposure to new strategies while continuing to utilize the skills that work best for each of us individually.

☐ **Assessment:**

Facilitator:

- Puts the stress scale on the projector and discusses how important it is that we begin to build awareness of our stress levels. When we increase awareness, we are then able to implement skills to reduce our stress.
- Reads “It is really hard at times to balance a demanding job, family, and friends and sometimes we don’t get to stop and check-in with ourselves. I would like to encourage that we begin to check-in with ourselves daily. Often, when we think about how stress affects us, we don’t always think about how stress affects our thoughts, feelings, body, and behaviors. It is important that we are able to identify these signs early so that we can reduce our stress and get back on track. Let’s take 2 minutes to reflect on how stress may be affecting our thoughts, behaviors, feelings, and body. Let’s look at the visual stress scale and we will each state our stress level number to the group”.
- states “as we begin to acknowledge our stress, we will be able to make modifications to our daily tasks and begin to implement protective strategies.

The stress score serves two purposes. It helps participants build awareness, but also lets the facilitator know what stress level the participant is at. Even if they are unable to express what is contributing to their stress in the group, the facilitator can check in later or in supervision. It’s important for the facilitator and the individual member to begin to understand what types of work-related events increase stress for that member.

☐ **Learning:**

Facilitator:

- begins by showing the “Supporting Resilience” video, and points out how Stress-Less is a model to increase our individual qualities of resilience as well as our social and organizational support for secondary traumatic stress
- asks the members about their thoughts or reactions to the video
- Is it in line with how you used to think about resilience?

☐ **Process:**

Facilitator:

- can use guiding questions to help facilitate discussion:
 - What do you hope to get out of this group?
 - What goals do you have for yourself?
 - What do you see as your strengths in this work?
 - What are your challenges?
 - Are there things we can do as a team to support each other more?
- Facilitator can state that he/she hopes that participants can trust her/him more and that he/she can do a better job at supporting participants and relieving some of their stress.

At the end of each process session, facilitator thanks members for sharing and for supporting one another. Facilitator can also share in the process portion if it will be helpful to the team. Just remember that since you are not actively doing the same work and there exists a power difference that your advice may not go as far as other members in validating each other and sharing support.

☐ **Skill:**

- Headspace Application

Facilitator:

- reminds the group that each session, participants will rotate taking turns introducing a new skill to the group. The goal is that we remain accountable for 3 skills that we keep in our tool box and practice regularly. By introducing new skills each session, participants can practice skills that may work for their individual needs. It also exposes us to new skills that we may not realize can be beneficial.
- states that today, we will be using an application called Headspace.

- downloads the Headspace application on their phone prior to group and connects their phone using the VGA Adapter to the projector so that the app runs on the projector.
- turns off the lights, encourages each participant to get comfortable, and lets them know that they can move places, turn their chairs around or do whatever they need to feel more at ease. Facilitator begins the 10 minute level 1 session of Headspace and participates in the meditation as well.
- After the 10 minutes are over, ask participants how they feel and what they thought of the skill. For those who found it helpful, facilitator encourages them to download the application on their phone so they can access it at any time.
- asks if any member would like to volunteer for introducing a skill next session.
- states that at the end of each session, we will all go around and state 3 skills that we are currently using to help us stay healthy. We are committing to practicing these skills regularly.
- asks members to state their 3 skills.
- ends by thanking everyone for sharing and announces when the next session will take place.

Session 2: Understanding Secondary Traumatic Stress

Materials: Stress Scale, *Provider Resilience Application, *Handout 1 (NCTSN: Secondary Traumatic Stress), A/V with projector, Lightning VGA Adapter (optional)

Facilitator:

- thanks everyone for coming to session
- states that he knows how busy each members' schedules are, but that he/she is happy that we commit to this time together to make our own health a priority so we can be the best we can be to ourselves and to our clients/patients.

☐ **Assessment:**

Facilitator:

- will put the stress scale on the projector
- Asks participants to take 5 minutes and reflect on their thoughts, behaviors, feelings and physical body reactions and assess how stress has been impacting them
- Asks if any member would like to start with the check-in by sharing their stress score and their high and low of the week
- Each member will share their stress score and their high and low of the week with the team
- It's important for the facilitator to participate in all activities

Facilitator:

- asks members to download the "Provider Resilience Application" on their phone.
- explains that the ProQOL is the most commonly used measure of the negative and positive effects of helping others who experience suffering and trauma. The ProQOL also has sub-scales for compassion satisfaction, secondary traumatic stress, and burnout and helps us to identify areas of need
- explains that we will use this app together every 3 months, but encourages everyone to use it regularly
- encourages each member to complete this honestly as she/he recognizes that this is very sensitive information. Facilitator explains that these measures often change over time and are not a reflection or indication of a participant's job performance, but a way for the members and the facilitator to better understand each of your needs while engaging in intense trauma work. Facilitator needs to complete as well.
- Thanks all participants for completing.
- reminds participants that in addition to increasing awareness of stress, it is also very important to regularly screen to see how we are doing. If we are able to identify what areas we are struggling in, we will be able to implement strategies to increase our resilience.

□ **Learning:**

Facilitator:

- introduces today's topic which is "Understanding Secondary Traumatic Stress"
- passes out Handout 1 (NCTSN: What is Secondary Traumatic Stress)
- identifies key points:
 - Reviews differences between STS, VT, compassion fatigue, and burnout
 - Reviews symptoms of STS
 - Asks what do you think about the list of symptoms? Are there others that should be included?
 - Review risk factors
 - Women
 - Highly empathic
 - Unresolved personal trauma
 - Heavy caseloads
 - Socially or professionally isolated
 - Feel professionally compromised due to inadequate training
- Asks "what are your thoughts on the risk factors mentioned? Do you agree? Why or why not?"
- It is important to note that this list includes things that we can do as an organization to decrease risk

It is important to explain that reviewing risk factors is meant to be a reflective tool and not to insinuate that if you have these qualities that you will automatically have STS. Risk factors can help identify some of the characteristics that may increase our risk.

- Normalize and validate that STS is a normal process for abnormal work experiences. Just as we normalize trauma symptoms for our clients, it is also important that we understand these symptoms as a reflection of the work we do, and not as a reflection of us as workers. This is a systems problem and not an individual problem.
- Reviews STS using the Ecological Model and discusses the following points:
 - In our society there is so much focus on STS being an individual level issue. Self-care is always given as the cure-all. Self-care is important, but it does not capture the whole picture. STS is not just an individual issue, it is very much a systems issue and needs to be addressed on several levels.
 - At the individual level, we have our personality, our coping styles, and our personal trauma history
 - At the interpersonal level, we look at our relationships with clients, friends, family; what support is available and how we utilize it
 - At the organizational level, we look at work climate, caseloads, trauma exposure, type and quality of supervision

- The community level is often overlooked when understanding STS; the community we work in; the systems that serve our clients, the injustice and structural racism that our clients face and we experience- adds another trauma layer to our work in advocating for clients
- Facilitator:
Asks members to reflect on what factors they believe contribute the most for them on all 4 levels?

☐ **Process:**

- Facilitator can use guiding questions to help facilitate discussion:
 - Can anyone share any difficult client experiences that they have gone through recently or in the past and how they affected you?
 - Can anyone share some STS symptoms that they have experienced and things that helped to relieve the symptoms?

The goal of this process component is to try to get participants in the habit of sharing very difficult events or experiences that they are currently facing. These can be in the form of cases that cause intense emotional reactions, cases where participants feel ineffective, cases where the outcome is socially unjust, ethical issues, and/or expressing their own physical, emotional, behavioral, or cognitive symptoms as a result of the trauma work. It is an opportunity to help each member problem solve and realize they are not alone in this work.

☐ **Skill:**

Facilitator:

- asks the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly
- thanks the participant for sharing the skill, and ask for another participant to introduce the next skill at the next session
- asks each member to state the 3 self-care skills that they commit to practicing regularly
- thanks everyone for coming and supporting one another

Session 3: Our Journey

Materials: Stress Scale, A/V with projector, Handout 2 (Career Mapping), paper scrolls, art supplies

☐ **Assessment:**

Facilitator:

- thanks everyone for coming
- asks if any member would like to start with the check-in. Each member (and facilitator) will share their stress scores and high and low of the week with the team

☐ **Learning:**

Facilitator:

- introduces today's learning topic, which is "Our Journey", and tells participants that today we will be designing our own timeline of our career
- passes out Handout 2 (timeline instructions), scrolls of paper and supplies to participants
- states that we will all individually complete our timelines and then come together to share and discuss them (please only include items that you are comfortable sharing with the team)
- Participants are provided 25 minutes to complete this activity.

☐ **Process:**

Facilitator can use guiding questions to help facilitate discussion:

- Encourages each member to share their timeline with the team and point out the decisions and values that led them to this work
- Do you share some similar values and beliefs with other participants?
- As you hear some of the other team members share, can you comment on some of the resilient qualities you see in other members?
- (PP) points out how much they helped each of us realize what led us to do this work. For some of us, our timelines are just beginning and some of us have been in this field for several years. Some of you mentioned positive or negative events in your lives that led you in a certain direction, some mentioned positive or negative relationships that guided your path, and others mentioned opportunities that may have presented themselves along the way. One thing we can take away from that activity is that we all do very similar work but had very different paths in getting to this place in our lives.

- (PP) We all have our own individual histories, values, beliefs and culture, which affect how we engage in this work, what we perceive as stress, and what we require to manage or reduce it.

☐ **Skill:**

Facilitator:

- asks the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly
- thanks the participant for sharing the skill, and ask for another participant to introduce the next skill at the next session
- asks each member to state the 3 self-care skills that they commit to practicing regularly
- thanks everyone for coming and supporting one another

Session 4: Power and Control

Materials: Stress Scale, A/V with projector, Handout 3 (Control Worksheet)

☐ **Assessment:**

Facilitator:

- thanks everyone for coming
- asks if any member would like to start with the check-in. Each member (and facilitator) will share their stress scores and high and low of the week with the team

☐ **Learning:**

Facilitator:

- introduces today's learning topic, which is "Power and Control"
- (PP) Often the things that we don't have control over can cause us the most stress, and it is important to acknowledge and process our feelings about this in order to increase resilience
- (PP) encourages the group to think about the concepts of power and control and how they affect us individually, our work with clients, and our work within systems
- provides participants with Handout 3 (Control Worksheet) and asks participants to think about their work and complete the worksheet by writing down things that they do not have control over
- leads a discussion around themes that come out of this exercise
- asks participants to now write down things they do have control over
- leads a discussion around themes that come out of this exercise

☐ **Process:**

Facilitator: can use guiding questions to help facilitate discussion:

- How do you help your clients when they feel powerless?
- If you had unlimited power, what would you change?
- How do you manage the injustice that you see?
- What are things that have helped you let go of things you can't control?
- In what ways can you shift your resources or energy into the things you have control over in your work?

☐ **Skill:**

Facilitator:

- asks the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly
- thanks the participant for sharing the skill, and ask for another participant to introduce the next skill at the next session
- asks each member to state the 3 self-care skills that they commit to practicing regularly
- thanks everyone for coming and supporting one another

Session 5: Empathy's Cousin

Materials: Stress Scale, Provider Resilience App, A/V with projector

☐ **Assessment:**

Facilitator:

- thanks everyone for coming
- asks if any member would like to start with the check-in. Each participant (and facilitator) will share their stress score and their high and low of the week with the team.
- Asks participants to take out their phones and to complete the ProQOL on the Provider Resilience app. Facilitator gives approximately 5 minutes to complete this and asks members to reflect on their scores this time compared to 3 months ago.

☐ **Learning:**

Facilitator:

- introduces today's learning topic which is "Empathy's Cousin"
- asks members to take turns reading the slides on Empathy
- (PP) The human connection is so important in our work. We would not be effective without our ability to try and understand how other people feel in their current circumstances.
- (PP) In order to have empathy, we need to be present with another person and in the process we open ourselves up to the potential of experiencing some of their pain. Empathy is a quality that can increase our risk for STS but it is also a protective factor.
- (PP) If we are exposed to an extensive amount of trauma, we run the risk of absorbing too much pain, loss, and injustice which could lead to STS.
- (PP) We also absorb the positive effects of connecting and being in a trusting relationship with others. We also absorb the strength, resilience, and transformation that we often witness with clients
- (PP) If we think of empathy on a spectrum, and something we can control- we can adjust how much empathy (and personalization) we allow at any given time.
- (PP) By decreasing personalization, it means that we can have empathy but we don't need to "feel" our client's pain.
- (PP) We can increase our empathy (and personalization) when it is needed to perform a certain function or during times that we want to feel the great rewards of this work. We can decrease or mute our empathy (and personalization) at times of increased trauma exposure and we have an existing connection with our clients.
- (PP) When we practice from a slightly less personalized lens, we are not absorbing the trauma or loss our clients often encounter. We are able to best serve our clients from this approach and also increase our own capacity, longevity, and personal health

- (PP) Can you think about a time in which you were really affected by a client experience?
- (PP) Can you reflect on what it was about this experience that affected you so much?

☐ **Process:**

Facilitator: can use guiding questions to help facilitate discussion:

- What are your thoughts about being able to control levels of empathy?
- Have you found ways to do this successfully?
- Does lessening our empathy mean that we care less?
- What are some barriers of this approach?
- What are some benefits of this approach?

☐ **Skill:**

Facilitator:

- asks the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly
- thanks the participant for sharing the skill, and ask for another participant to introduce the next skill at the next session
- asks each member to state the 3 self-care skills that they commit to practicing regularly
- thanks everyone for coming and supporting one another

Session 6: Plan for Resilience

Materials: Stress Scale, A/V with projector, Handout 4 (Symptom Checklist), Handout 5 (Wellness Action Plan), Handout 6 (My Action Plan)

☐ **Assessment:**

Facilitator:

- thanks everyone for coming
- asks if any member would like to start with the check-in. Each participant (and facilitator) will share their stress score and their high and low of the week with the team.

☐ **Learning:**

Facilitator:

- introduces today's learning topic, which is "Plan for Resilience"
- (PP) the goal of this session is to prepare each participant with very clear steps of what to do when they experience overwhelming thoughts, feelings, behaviors, or physical symptoms related to their work.
- states as discussed in an earlier session, we reviewed the concept of secondary traumatic stress, and how it is a normal and common reaction to the work we engage in daily. Today, we will have a deeper discussion regarding symptoms and review how to get back on a path of wellness if we are experiencing intense reactions.
- provides each participant with Handout 4 (Symptom Checklist), Handout 5 (Wellness Action Plan), and Handout 6 (My Action Plan)
- begins by asking participants to read the slides on the Symptom Checklist
- (PP) stress can manifest in our thoughts, feelings, behaviors, and bodies and it is important when we check in with ourselves to think about all four of these domains. So often, we check in on the feelings level and not pay attention to our bodies
- (PP) We all probably have experienced some of these symptoms at one time or another. I want to encourage us not to be ashamed of these symptoms or try and avoid them but to accept them, and look at them as a signals to our body that we need to implement some strategies to reduce our stress response
- asks participants to take turns reading each step on Handout 5 (Wellness Action Plan) out loud to the group
- encourages participants to keep Handout 5 accessible so that they can use it anytime they are feeling stressed or overwhelmed by the work.
- Asks participants to complete Handout 6 and discuss.

☐ **Process:**

Facilitator: can use guiding questions to help facilitate discussion:

- When reviewing Handout 4, where do stress symptoms manifest first (thoughts, feelings, behaviors, or body reactions)?
- Does anyone want to share any current symptoms they may be experiencing?
- Does anyone want to share how they may have overcome some stressful work times?
- What are your thoughts regarding the Wellness Action Plan?
- Do you think this is something that you will use if you find yourself experiencing intense symptoms?
- What are some of the self-care strategies that you listed on your Action Plan?

☐ **Skill:**

Facilitator:

- asks the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly
- thanks the participant for sharing the skill, and ask for another participant to introduce the next skill at the next session
- asks each member to state the 3 self-care skills that they commit to practicing regularly
- thanks everyone for coming and supporting one another

Session 7: Acknowledging both Rewards and Challenges

Materials: Stress Scale, A/V with projector, Handout 7 (STS and Vicarious Resilience quotes)

☐ **Assessment:**

Facilitator:

- thanks everyone for coming
- asks if any member would like to start with the check-in. Each member (and facilitator) will share their stress scores and high and low of the week with the team

☐ **Learning:**

Facilitator:

- introduces today's learning topic which is "Acknowledging both Rewards and Challenges"
- begins by stating how much respect she has for everyone in the room for their commitment to this work. He/she validates how incredibly difficult this work is, but also at the same time, how incredibly rewarding it can be
- provides Handout 7 to participants and asks each person to take turns reading the quotes out loud. After each quote, facilitator asks the group if they can identify with the quote and discuss what aspects resound with them
- leads a discussion and asks participants to share their thoughts regarding their individual challenges of this work
- Facilitator leads a discussion and asks participants to share their thoughts regarding their individual benefits of this work.

☐ **Process:**

Facilitator: can use guiding questions to help facilitate discussion:

- What keeps us motivated in doing this work?
- How can we magnify/celebrate the rewards of this work more?
- What are some factors that would decrease the challenges of this work?

☐ **Skill:**

Facilitator:

- asks the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly
- thanks the participant for sharing the skill, and ask for another participant to introduce the next skill at the next session
- asks each member to state the 3 self-care skills that they commit to practicing regularly
- thanks everyone for coming and supporting one another

Session 8: The U in Trauma

Materials: Stress Scale, A/V with projector, *Handout 8 (Know Your Triggers)

☐ **Assessment:**

Facilitator:

- thanks everyone for coming
- asks if any member would like to start with the check-in. Each member (and facilitator) will share their stress scores and high and low of the week with the team
- asks each participant to complete the ProQOL in the Provider Resilience Application and to reflect on where they are in the areas of compassion satisfaction, burnout, and STS

☐ **Learning:**

Facilitator:

- introduces today's learning topic, which is "The U in Trauma"
- explains that today we are going to reflect on identifying our own personal stressors and triggers.
- Provides each member with Handout 7 (Know Your Triggers)
- (PP) Trauma-informed care includes the understanding that we all come into this work with our own histories. As individuals working with clients who have undergone extensive trauma, it is critical to reflect on our own history and identify stressors and triggers that potentially can have a negative impact on us and our work with clients. If we know our triggers, then we are able to utilize resources during increased times of stress.
- Asks members to take 10 minutes and complete the exercise
- Each member discusses their stressors and triggers with the team and the resources they would utilize

☐ **Process:**

Facilitator: can use guiding questions to help facilitate discussion:

- Can anyone discuss a time that they have been triggered in this work?
- How did you cope?
- Are there things that would be helpful for your teammates to know to best support you during a stressful time?

☐ **Skill:**

Facilitator:

- asks the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly
- thanks the participant for sharing the skill, and ask for another participant to introduce the next skill at the next session
- asks each member to state the 3 self-care skills that they commit to practicing regularly
- thanks everyone for coming and supporting one another

Session 9: Stay the Course

Materials: Stress Scale, *The Importance of Boundaries (youtube), Handout 9 (Self-Care Grid), A/V with projector,

☐ **Assessment:**

Facilitator:

- thanks everyone for coming
- asks if any member would like to start with the check-in. Each participant (and facilitator) will share their stress score and their high and low of the week with the team.

☐ **Learning:**

Facilitator:

- Passes out Handout 9 (Self-Care Grid)
- introduces today's learning topic, which is "Stay the Course"
- plays the youtube video, "The Importance of Boundaries"
- (PP) Having good boundaries can be a challenge in our work because we work with such vulnerable populations. It is difficult when clients and families invite you into their lives at such vulnerable times, and the thought of creating boundaries can feel like we are putting up walls of separation when client and families may need us the most. Boundaries are not meant to divide us from our clients, but the everyday "yes" or "no's" help us balance our priorities, time, and energy. We are often taught that boundaries are there to protect our feelings, but boundaries are as much for our clients as they are for us. We have an obligation to protect our clients and set realistic expectations with them.
- Give participants 15 minutes to complete the self-care grid
- Ask participants to discuss one thing that they learned about themselves from doing this activity

☐ **Process:**

Facilitator: can use guiding questions to help facilitate discussion:

- Do you think having boundaries is important? Why or why not?
- What are some challenges of having to implement boundaries with clients?
- How can we implement boundaries and not make clients feel that we are pushing them away?
- What are some signs that let us know that our energy is drained and we need to refuel?

☐ **Skill:**

Facilitator:

- asks the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly
- thanks the participant for sharing the skill, and ask for another participant to introduce the next skill at the next session
- asks each member to state the 3 self-care skills that they commit to practicing regularly
- thanks everyone for coming and supporting one another

Session 10: How Do We Measure Success?

Materials: Stress Scale, A/V with projector, Handout 10 and 11 (Case Studies)

☐ **Assessment:**

Facilitator:

- thanks everyone for coming
- asks if any member would like to start with the check-in. Each member (and facilitator) will share their stress scores and high and low of the week with the team

☐ **Learning:**

Facilitator:

- introduces today's learning topic which is "How Do We Measure Success".
- provides each member with Handout 10 (Case Studies), and asks a participant to volunteer and read the first case study
- asks participants to underline any potential successes that they heard in the case example
- (PP) asks participants to answer the following questions:
 - What are your reactions to this case?
 - Name some of the strengths you heard?
 - Name some of the challenges?
 - What is your hope for Maria, for Jessica, for the family?
 - How does it feel to have to close a case at this point?
- (PP) leads a discussion about:
 - How do you define success with your clients?
 - How do you manage your expectations of what you hope the outcome will be?
 - What are some strategies that can help us stay optimistic and positive despite our client's challenges?
- Asks a participant to volunteer and read the 2nd case study
- asks participants to imagine working with the client at different time points and to reflect on this particular client's adversity and resilience throughout time
- points out that we often may not get to see the benefits of our work in the time that we work with clients. We often plant seeds and don't have control over how or when they grow
- Another important point is that what we may consider trauma/adversity, our clients may not, and vice versa
- (PP) If we reflect on our own timelines, we can often see that very difficult times in our own life, were followed by a period of growth for us. We don't always know what affect or meaning a particular experience (even a bad one) will have on a client's life or what potential growth can look like for that client.

☐ **Process:**

Facilitator: can use guiding questions to help facilitate discussion:

- Do you individually, do we (as a team/organization) take enough time to celebrate the small victories in our work?
- How do we make meaning in this work?
- Are you able to see successes or positive experiences in difficult times?
- What are some internal rewards you get from this work?
- What are some external rewards you get from this work?

☐ **Skill:**

Facilitator:

- asks the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly
- thanks the participant for sharing the skill, and ask for another participant to introduce the next skill at the next session
- asks each member to state the 3 self-care skills that they commit to practicing regularly
- thanks everyone for coming and supporting one another

Session 11: Mind Full

Materials: Stress Scale, A/V with projector,

☐ **Assessment:**

Facilitator:

- thanks everyone for coming
- asks if any member would like to start with the check-in. Each member (and facilitator) will share their stress scores and high and low of the week with the team

☐ **Learning:**

Facilitator:

- introduces today's learning topic, which is "Mind Full"
- plays the youtube videos, "Mind the Bump" and "Mindful vs. Mindless"
- (PP) Trains your mind to allow thoughts to be born, hover and then pass away; Controlling reactions now to learn how to control them in the future; Lower natural emotional arousal to prepare for real life; More practice will make it easier to use in everyday life when you get "stuck" outside the moment!; Keep your brain from telling your body when there is a false threat.

☐ **Process:**

Facilitator: can use guiding questions to help facilitate discussion:

- How do you disconnect from work?
- Is it hard to be present at home?
- What are some ways that we can increase mindfulness?

☐ **Skill:**

Facilitator:

- asks the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly
- thanks the participant for sharing the skill, and ask for another participant to introduce the next skill at the next session
- asks each member to state the 3 self-care skills that they commit to practicing regularly
- thanks everyone for coming and supporting one another

Session 12: Work/Life Balance

Materials: Stress Scale, A/V with projector, Provider Resilience Application, Handout 12 (Work/Life Balance)

☐ **Assessment:**

Facilitator:

- thanks everyone for coming
- asks if any member would like to start with the check-in. Each participant (and facilitator) will share their stress score and their high and low of the week with the team.
- asks each participant to complete the ProQOL in the Provider Resilience Application and to reflect on where they are in the areas of compassion satisfaction, burnout, and STS

☐ **Learning:**

Facilitator:

- introduces today's learning topic which is "Work/Life Balance"
- plays the Ted Talk, "the happy secret to better work"
- provides members with Handout 12 (What's in Your Buckets)
- asks members to take time and reflect on what's currently in their buckets and complete the worksheet
- (PP) asks members to answer the following questions:
 - What do you want your buckets to look like?
 - How can you have more balance in your life?
 - What is one thing you may need to change or give up to have more balance in your life?

☐ **Process:**

- Facilitator can use guiding questions to help facilitate discussion:
 - How do we distribute our time and energy across the buckets that are most important to us?
 - How can we regularly reflect on our values, needs, and purpose to make sure we are living the life we want?

☐ **Skill:**

- Facilitator will ask the participant to introduce their new skill to the group. The group will practice the skill together as a group. After the skill is practiced, the facilitator will ask participants how they liked the skill and if it's something that they can use regularly.
- Facilitator will thank the participant for sharing the skills, and ask for another participant to introduce the next skill.
- Facilitator asks each member to state the 3 self-care skills that they commit to practicing regularly.
- Thank all participants for participating and sharing.

Fidelity Check List

Stress-Less Initiative

Session 1	Y	N
1. Explain format and structure of group		
2. Set guidelines for group to be held accountable		
3. Create safe space for sharing		
4. Stress Scale, High-Low		
5. Group Resilience video and discussion		
6. Processing Component		
7. Headspace Skill Demonstration		

Session 2	Y	N
1. Stress scale, high/Low, Provider Resilience App		
2. Handout 1: Reviewing differences among concepts		
3. Review of symptoms		
4. Review of risk factors		
5. Review Social-Ecological Model		
6. Processing Component		
7. Skill		

Session 3	Y	N
1. Stress scale, High-Low		
2. Handout 2: Professional Timeline		
3. Processing Component		
4. Skill		

Session 4	Y	N
1. Stress Scale, high-low		
2. Handout 3: Power and Control		
3. Processing Component		
4. Skill		

Session 5	Y	N
1. Stress Scale, high-low, Provider Resilience app		
2. Review PP slides on Empathy		
3. Processing Component		
4. Skill		

Session 6	Y	N
1. Stress scale, high-low		
2. Handout 4: Stress symptoms		
3. Handout 5: Wellness Action Plan		
4. Handout 6: My Action Plan		
5. Processing Component		
6. Skill		

Session 7	Y	N
1. Stress scale, high-low		
2. Handout 7: STS and Vicarious Resilience		
3. Processing Component		
4. Skill		

Session 8	Y	N
1. Stress Scale, high-low, Provider Resilience App		
2. Handout 8: Know your triggers		
3. Processing Component		
4. Skill		

Session 9	Y	N
1. Stress scale, high-low		
2. Boundaries youtube video		
3. Handout 9: Self-Care Grid		
4. Processing Component		
5. Skill		

Session 10	Y	N
1.Stress scale, high-low		
2. Handout 10: Case Study		
3. Handout 11: Case Study		
4. Processing Component		
5. Skill		

Session 11	Y	N
1.Stress scale, high-low		
2. Video: Mind the Bump		
3. Video: Mindful vs. Mindless		
4. Processing Component		
5. Skill		

Session 12	Y	N
1.Stress scale, high-low, Provider Resilience App		
2. Video: Happy Secret to Better Work		
3. Handout 12: Know your Buckets		
4. Processing Component		
5. Skill		



Secondary Traumatic Stress

A Fact Sheet for Child-Serving Professionals

“...We are stewards not just of those who allow us into their lives but of our own capacity to be helpful...”¹

Each year more than 10 million children in the United States endure the trauma of abuse, violence, natural disasters, and other adverse events.² These experiences can give rise to significant emotional and behavioral problems that can profoundly disrupt the children’s lives and bring them in contact with child-serving systems. For therapists, child welfare workers, case managers, and other helping professionals involved in the care of traumatized children and their families, the essential act of listening to trauma stories may take an emotional toll that compromises professional functioning and diminishes quality of life. Individual and supervisory awareness of the impact of this indirect trauma exposure—referred to as **secondary traumatic stress**—is a basic part of protecting the health of the worker and ensuring that children consistently receive the best possible care from those who are committed to helping them.

Our main goal in preparing this fact sheet is to provide a concise overview of secondary traumatic stress and its potential impact on child-serving professionals. We also outline options for assessment, prevention, and interventions relevant to secondary stress, and describe the elements necessary for transforming child-serving organizations and agencies into systems that also support worker resiliency.

How Individuals Experience Secondary Traumatic Stress

Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of posttraumatic stress disorder (PTSD). Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal

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Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary traumatic stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

Compassion fatigue, a label proposed by Figley⁴ as a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with that term.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client.¹³ It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material. The primary symptoms of vicarious trauma are disturbances in the professional's cognitive frame of reference in the areas of trust, safety, control, esteem, and intimacy. **Burnout** is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.

Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.

resources; and disruption in their perceptions of safety, trust, and independence. A partial list of symptoms and conditions associated with secondary traumatic stress includes³ n Hypervigilance n Hopelessness n Inability to embrace complexity n Inability to listen, avoidance of clients n Anger and cynicism n Sleeplessness n Fear n Chronic exhaustion n Physical ailments n Minimizing n Guilt

Clearly, client care can be compromised if the therapist is emotionally depleted or cognitively affected by secondary trauma. Some traumatized professionals, believing they can no longer be of service to their clients, end up leaving their jobs or the serving field altogether. Several studies have shown that the development of secondary traumatic stress often predicts that the helping professional will eventually leave the field for another type of work.^{4,5}

Understanding Who is at Risk

The development of secondary traumatic stress is recognized as a common occupational hazard for professionals working with traumatized children. Studies show that from 6% to 26% of therapists working with traumatized populations, and up to 50% of child welfare workers, are at high risk of secondary traumatic stress or the related conditions of PTSD and vicarious trauma.

Any professional who works directly with traumatized children, and is in a position to hear the recounting of traumatic experiences, is at risk of secondary traumatic stress. That being said, risk appears to be greater among women and among individuals who are highly empathetic by nature or have unresolved personal trauma. Risk is also higher for professionals who carry a heavy caseload of traumatized children; are socially or organizationally isolated; or feel professionally compromised due to inadequate training.⁶⁻⁸ Protecting against the development of secondary traumatic stress are factors such as longer duration of professional experience, and the use of evidence-based practices in the course of providing care.⁷

Identifying Secondary Traumatic Stress

Supervisors and organizational leaders in child-serving systems may utilize a variety of assessment strategies to help them identify and address secondary traumatic stress affecting staff members.

The most widely used approaches are *informal self-assessment* strategies, usually employed in conjunction with formal or informal education for the worker on the impact of secondary traumatic stress. These self-assessment tools, administered in the form of questionnaires, checklists, or scales, help characterize the individual's



trauma history, emotional relationship with work and the work environment, and symptoms or experiences that may be associated with traumatic stress.^{4,9}

Supervisors might also assess secondary stress as part of a *reflective supervision model*. This type of supervision fosters professional and personal development within the context of a supervisory relationship. It is attentive to the emotional content of the work at hand and to the professional's responses as they affect interactions with clients. The reflective model promotes greater awareness of the impact of indirect trauma exposure, and it can provide a structure for screening for emerging signs of secondary traumatic stress. Moreover, because the model supports consistent attention to secondary stress, it gives supervisors and managers an ongoing opportunity to develop policy and procedures for stress-related issues as they arise.

Formal assessment of secondary traumatic stress and the related conditions of burnout, compassion fatigue, and compassion satisfaction is often conducted through use of the Professional Quality of Life Measure (ProQOL).^{7,8,10,11} This questionnaire has been adapted to measure symptoms and behaviors reflective of secondary stress. The ProQOL can be used at regular intervals to track changes over time, especially when strategies for prevention or intervention are being tried.

Strategies for Prevention

A multidimensional approach to prevention and intervention—involving the individual, supervisors, and organizational policy—will yield the most positive outcomes for those affected by secondary traumatic stress. The most important strategy for preventing the development of secondary traumatic stress is the triad of psychoeducation, skills training, and supervision. As workers gain knowledge and awareness of the hazards of indirect trauma exposure, they become empowered to explore and utilize prevention strategies to both reduce their risk and increase their resiliency to secondary stress. Preventive strategies may include self-report assessments, participation in self-care groups in the workplace, caseload balancing, use of flextime scheduling, and use of the self-care accountability buddy system.

Proper rest, nutrition, exercise, and stress reduction activities are also important in preventing secondary traumatic stress.

Prevention

[n](#) Psychoeducation [n](#) Clinical supervision [n](#) Ongoing skills training [n](#) Informal/formal self-report screening [n](#) Workplace self-care groups (for example, yoga or meditation) [n](#) Creation of a balanced caseload [n](#) Flextime scheduling [n](#) Self-care accountability buddy system [n](#) Use of evidence-based practices [n](#) Exercise and good nutrition

Strategies for Intervention

Although evidence regarding the effectiveness of interventions in secondary traumatic stress is limited, cognitive-behavioral strategies and mindfulness-based methods are emerging as best practices. In addition, caseload management, training, reflective supervision, and peer supervision or external group processing have been shown to reduce the impact of secondary traumatic stress. Many organizations make referrals for formal intervention from outside providers such as individual therapists or Employee Assistance Programs. External group supervision services may be especially important in cases of disasters or community violence where a large number of staff have been affected.

The following books, workbooks, articles, and self-assessment tests are valuable resources for further information on self-care and the management of secondary traumatic stress:

Intervention

- n Strategies to evaluate secondary stress
- n Cognitive behavioral interventions
- n Mindfulness training n Reflective supervision n Caseload adjustment n Informal gatherings following crisis events (to allow for voluntary, spontaneous discussions)
- n Change in job assignment or work group
- n Referrals to Employee Assistance Programs or outside agencies

- n Volk, K.T., Guarino, K., Edson Grandin, M., & Clervil, R. (2008). *What about You? A Workbook for Those Who Work with Others*. The National Center on Family Homelessness. <http://508.center4si.com/SelfCareforCareGivers.pdf>
- n *Self-Care Assessment Worksheet* http://www.ecu.edu/cs-dhs/rehb/upload/Wellness_Assessment.pdf
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Worker Resiliency in Trauma-informed Systems: Essential Elements

Both preventive and interventional strategies for secondary traumatic stress should be implemented as part of an organizational risk-management policy or task force that recognizes the scope and consequences of the condition. The Secondary Traumatic Stress Committee of the National Child Traumatic Stress Network has identified the following concepts as essential for creating a trauma-informed system that will adequately address secondary traumatic stress. Specifically, the trauma-informed system must

- n Recognize the impact of secondary trauma on the workforce.
- n Recognize that exposure to trauma is a risk of the job of serving traumatized children and families.
- n Understand that trauma can shape the culture of organizations in the same way that trauma shapes the world view of individuals. n Understand that a traumatized organization is less likely to effectively identify its clients' past trauma or mitigate or prevent future trauma.
- n Develop the capacity to translate trauma-related knowledge into meaningful action, policy, and improvements in practices.

These elements should be integrated into direct services, programs, policies, and procedures, staff development and training, and other activities directed at secondary traumatic stress.

“We have an obligation to our clients, as well as to ourselves, our colleagues and our loved ones, not to be damaged by the work we do.”¹²

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About the National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention

Handout 2: Your Professional Timeline

Instructions:

On the sheet in front of you, draw a horizontal line across the middle of the sheet. This line indicates the time span from when you first decided to go into this work. At the leftmost end of the line, write the year you decided you wanted to be a helping professional. At the rightmost end, write this year.

Now mark the intervening years. You may want to make the intervals evenly spaced, or, if some years seem longer than others, the intervals can reflect that.

On the left end of the line, in whatever colors fit, write the adjectives to describe who you were the year you decided to enter this field. You might describe yourself, your personality, the innate helping skills you brought to your vision of yourself in your future career. Think of a phrase to describe your frame of reference (world view) at that time and write it in.

Now, for the intervening years, I want you to do two things:

1. Above the line, write in events and milestones in your professional life; write these events (e.g. started school, first job) above the approximate year they occurred.
2. Below the line, in a different color, write in important personal events and milestones (relationships beginning or ending, births, deaths, moves, changes) and times of crisis or particular growth.

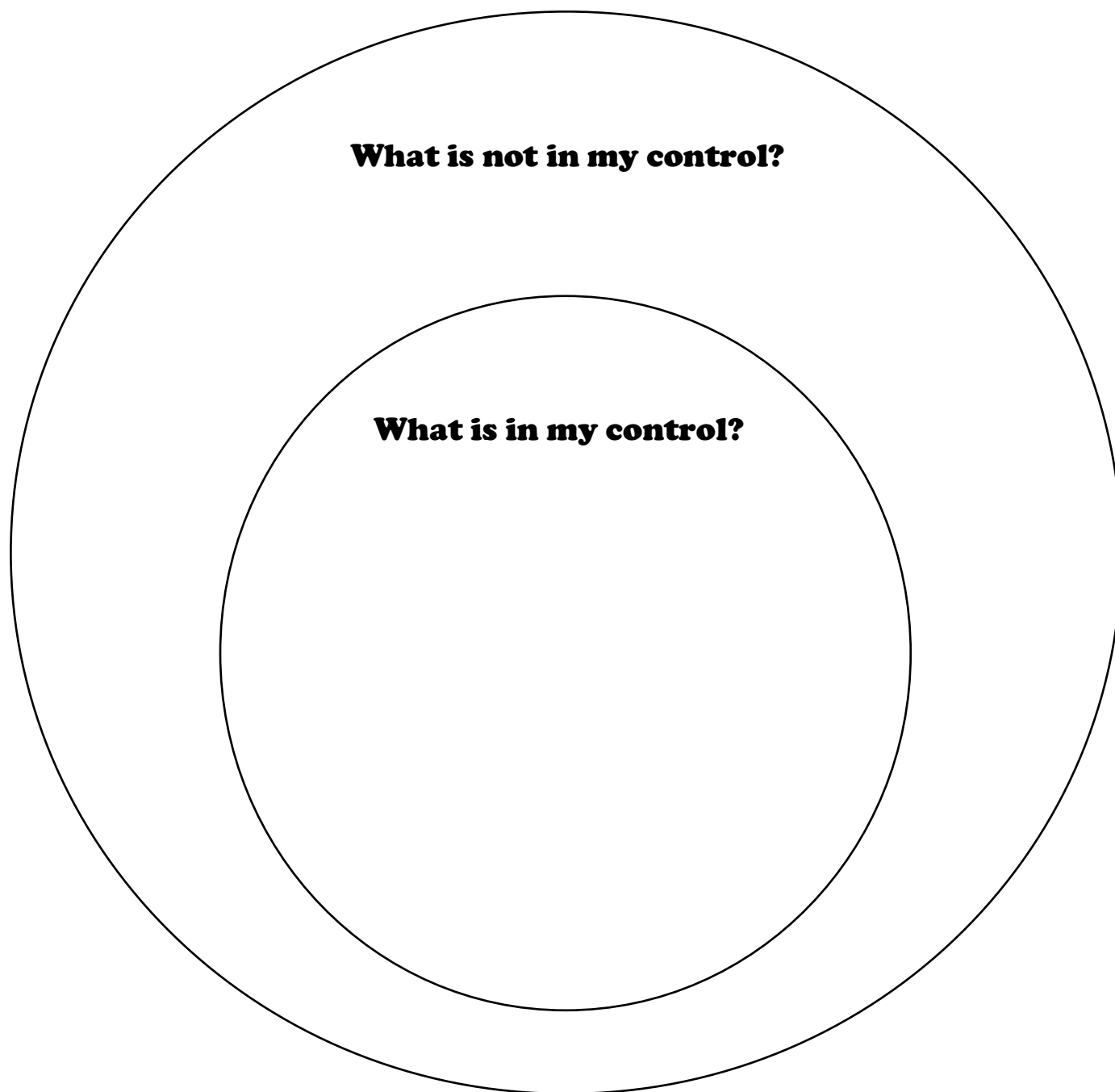
Now reflect on particular clients with whom you've worked over the years. Who are the individuals who have had a real impact on you? These may be some of your most difficult clients or some of your most enjoyable clients, those that taught you the most, clients who

took a toll on you, clients who inspired you. These people have changed you and stayed with you internally, as your reservoir of professional experience. On your timeline write the initials of these clients at the year or years when you worked with them.

Now, at the right end, by today's date, write in a description of yourself today. Include a phrase or sentence describing your current world view.

(Pearlman, 1996)

Handout 3: Power and Control



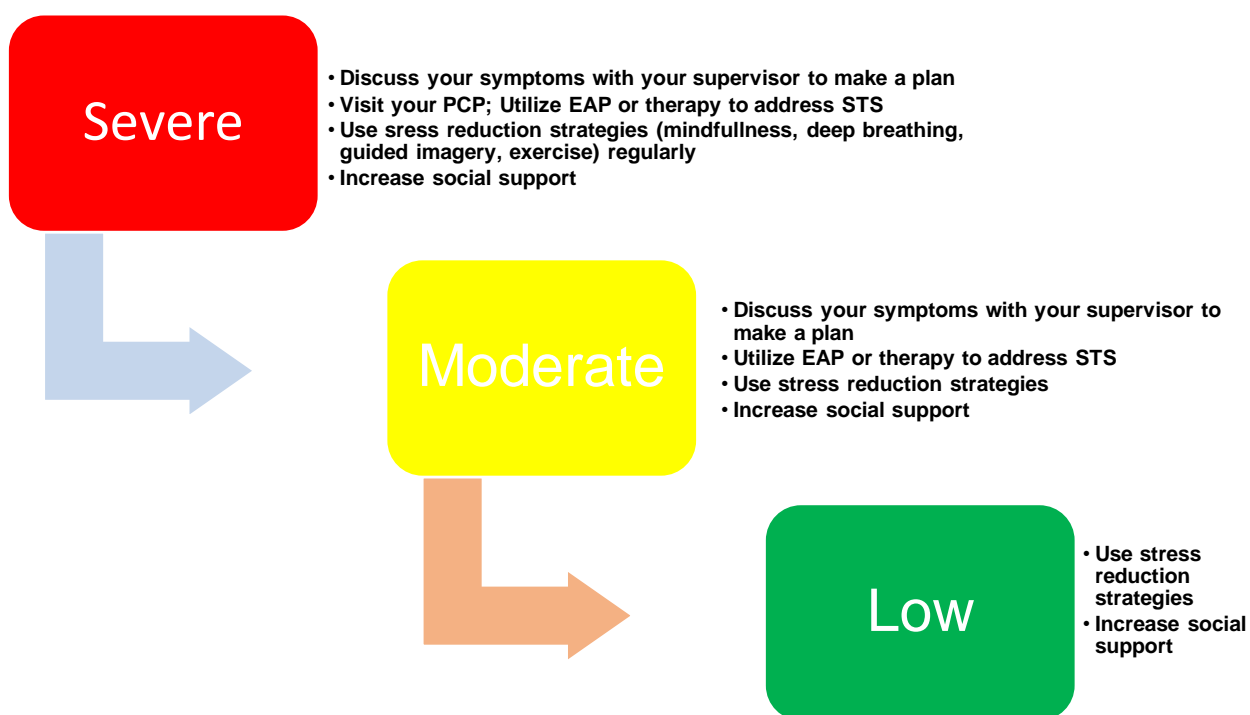
Handout 4: Warning Signs of Stress

Physical	Emotional	Cognitive	Behavioral
Back pain	Anxious	Lack of concentration	Alcohol use
Headaches	Anger	Forgetfulness	Smoking
Dizziness	Confusion	Nightmares	Drug use
Hair loss	Mood changes	Racing thoughts	Grinding teeth
Stomach aches	Irritability	Ruminating	Pacing/tapping
Jaw pains	Sadness	Dissociative	Yelling
Weight loss/gain	Feeling helpless	Intrusive Thoughts	Nail biting
Fatigue	Guilt	Rationalizing	Social withdrawal
Weakness	Fear	Minimizing	Changes in eating
Twitches	Hopelessness		Avoidance
+/- appetite	Nervousness		Diminished self-care
indigestion			+/- sleep
Nausea			
Chest pains			
High blood pressure			
Increased sweating			

Handout 5: Wellness Action Plan

There are times that we may feel overwhelmed in doing this work. As we have learned, stress can affect us physically, emotionally, cognitively, and behaviorally. When we experience an increase in our stress level (increase in symptoms), it is important to take the necessary steps to get our stress under control and get back on a path of wellness.

These are steps to follow based on symptom severity:



Handout 6: My Action Plan

In times of great distress, it can be difficult to know what support is available, and what strategies will help us decrease our stress. It is good to write down an action plan so that when stress arises, we will know what options we have and be able to take steps to feel better.

Instructions: Please reflect on what resources you have and strategies that have helped you feel better in the past.

Social Support: Who can you talk to about difficult experiences?

Self-Care Strategies: What activities help you to feel calm?

Body-Based Strategies: What are 3 things you can do to decrease stress immediately?

1.

2.

3.

Handout 7: Acknowledging Rewards and Challenges

(Sexual Abuse Counselor): “It’s a balance between the terribleness of it and the awful, awful stories that you hear and the amazement of people, what they’ve made of their lives. Something quite different and their values. I mean I’m hugely affected by these, [stories] but they’re really amazing. I’m constantly in awe really of some of the stories because, I mean, some I have to say: How on earth is this person still alive really? What is holding them?” (Pack, 2014)

Over time they developed the skills to create a delicate balance between being present for the client while at the same time not being “it” for the client. **(Trauma Therapist)** “You can’t be there for every child forever. You know, that is not my role. So, I’m separating from them, and that separation is sometimes extremely painful”. (Lonergan, O’Halloran & Crane, 2004)

(Trauma Therapist) “I think we don’t talk enough in graduate school and training about the experience of working with people in pain and the feeling that sometimes you can’t be helpful.” She made it clear that two important others in her life made a difference in helping her gain perspective: “During the worst time of my career, two people were instrumental. The DA called to remind me that I was not God and I couldn’t control the world, and a professor told me, “It’s not happening to you”. (Lonergan, O’Halloran & Crane, 2004)

(Psychiatrist) “The patients in the therapeutic relationship will want to please you, they will be aware of what we can handle, and may protect us by not giving us too much, just as they may have protected their parents. In order to keep yourself open to hearing what they bring, you have to monitor what is happening in yourself”. (Marriage & Marriage, 2005)

(Psychologist) “Working with dying patients gives me a perspective on what is important in life. At the end of the journey, most focus on relationships, rather than fame or fortune. And the experience humbles you...we are not always successful at saving patients. And then there is frustration and guilt- why do patients have to go through this?” (Marriage & Marriage, 2005)

(Psychiatrist) “Sharing the story with a colleague, reflecting on what it is like to sit with enormous trauma, can be part of an empathic exchange, a mentoring process. Realizing that times of sharing the worst stories are also times of potential growth for the patient. With longer experience, as you see people work through these things, it becomes easier to nurture a thread of hope for each client”. (Marriage & Marriage, 2005)

(Social Worker) “It touches you: you see the intimate parts of people’s lives. You realize there are more layers, gives you a different perspective-it is harder to be certain that things are not always what they seem. Your perspective changes as you learn more.... You must be emotionally available to be effective. So, you must keep a balance, while still being self-protective”. (Marriage & Marriage, 2005)

Handout 8: Personal Work Stressors and Triggers

Trauma-informed care is understanding how our client's past trauma history can affect their current ability to address their health and psycho-social needs. Trauma-informed care includes the understanding that we all come into this work with our own histories. As individuals working with clients who have undergone extensive trauma, it is critical to reflect on our own history and identify stressors and triggers that potentially can have a negative impact on us and our work with clients. If we know our triggers, then we are able to utilize resources during increased times of stress or when we are faced with our own triggers.

Name 3 personal work stressors:

- 1.**
- 2.**
- 3.**

Name 3 situations that come up with clients/families that have the potential to trigger you?

- 1.**
- 2.**
- 3.**

Name 3 resources you can utilize during times of increased work stress or if you are being triggered by a certain client or situation:

- 1.**
- 2.**
- 3.**

Handout 9: Self-Care Grid

	Physically	Emotionally	Mentally	Spiritually
What currently energizes me in my work?				
What saps my energy in my work?				
What would help to energize me more in my work?				
What holds me back from doing what would energize me more?				

Some examples of what you might enter into each column:

Physical	Emotional	Mental	Spiritual
Eating Drinking Sleeping Exercise Breaks Relaxation	Relationships Intimacy Empathy Processing emotions Balance Safety	Time management Creativity Thinking skills Challenge Mental preparation Reflection	Commitment Values A deeper purpose Prayer/meditation Giving to others Nature Stillness

Adapted from Loehr & Schwartz (2003)

Handout 10: How Do We Measure Success?

Case Study: Maria 2013

Maria is a 12 year-old Latino female who was referred to the Violence Intervention Program from the Trauma Unit. Maria was shot in the arm and the abdomen walking home from the store with her 14 year-old sister. She remained inpatient at the hospital for 3 weeks. During her stay, she had many visits from family and friends. Maria explained that the shooter came from behind the bushes on her property and was shooting at the apartment building next to her home. As a result, she was afraid to go home. Maria and her sister Jessica had profound PTSD symptoms. Maria's mother reached out to our Violence Intervention Program to get some help. Maria lived with her mother and father, older sister, and older brother. They were a very close knit family. Maria got good grades in school and loved to dance and do art. She was very upset that her injury was preventing her from dancing, but after 3 more weeks of therapy- she will be able to engage in physical activities.

In time, Maria healed physically, but the girls' emotional symptoms worsened; unable to sleep at night (only sleeping when it was light out), startled by loud noises, experiencing anxiety attacks, and intrusive thoughts. Directly after the incident, the girls would not return to the family home or to school, could not be in a different room than their mother, and avoided windows. Maria, her sister and mother went to temporarily stay with their oldest brother in a different neighborhood. However, both girls were able to talk about their symptoms and begin trauma-focused therapy and groups. We enrolled both girls in Cyber School where they felt safe enough to participate from their brother's home. We filed VCAP and helped the family navigate the legal system. However, the detectives were not very helpful and the case remains unsolved. Mother was also very overwhelmed and had a long trauma history, in addition to very complicated medical issues. We referred mother to therapy to address her own mental health needs. The girls' fears were complicated by the fact that the perpetrator was never arrested and the police stated that they had no leads. It became evident that the family needed to move residences in order for the girls to feel safe again, but there were no housing options available.

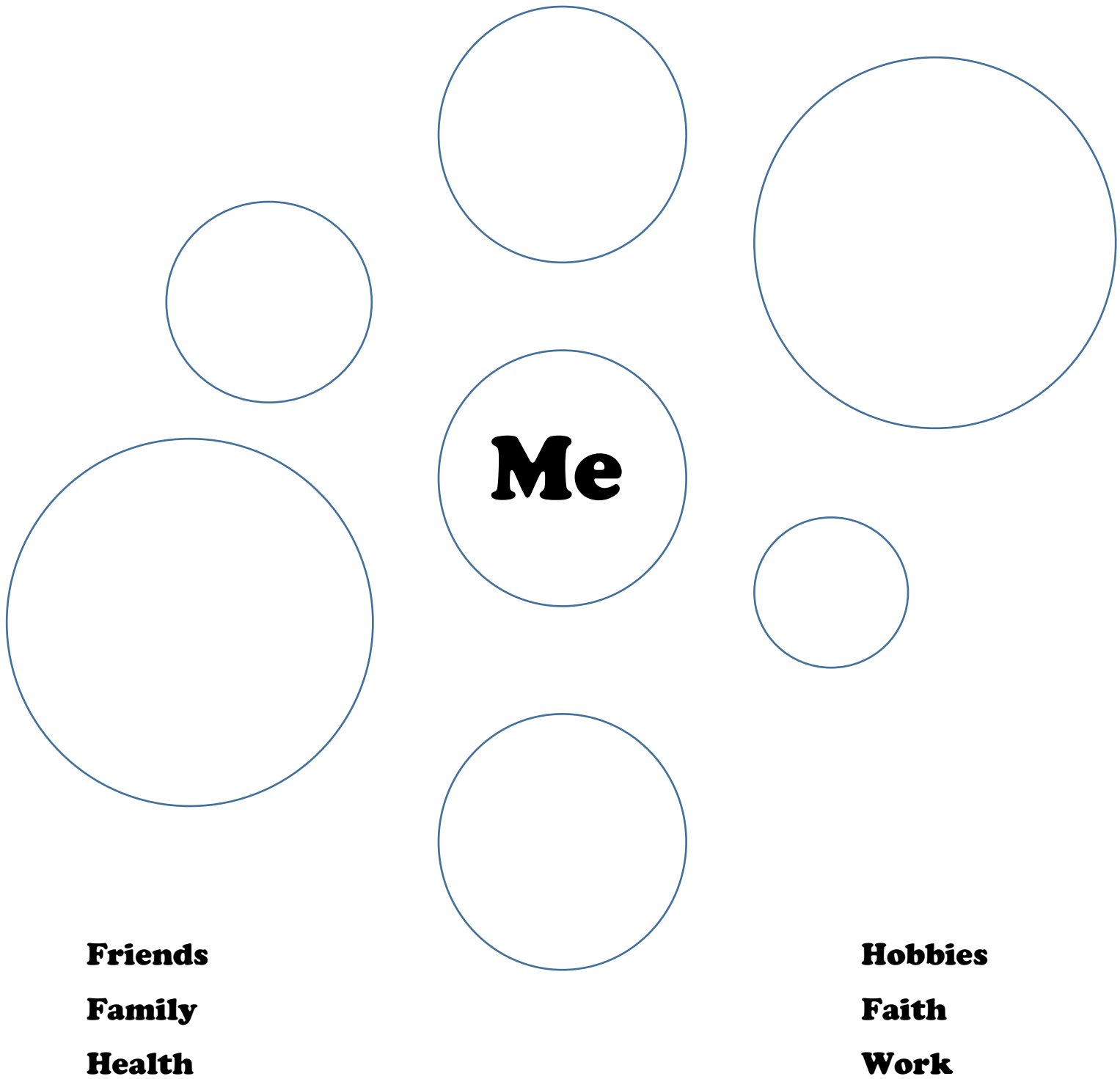
Handout 11: How Do We Measure Success?

Case Study: Maria 2015

Maria is now 14 years-old and is starting the 9th grade at a public school. Her family had moved out of the city into a home on a very safe block. Maria still gets anxiety, but is able to sleep better and now is able to go out and spend time with friends. She loves makeup and likes to do tutorials online and teach others. Jessica is in the 11th grade at a public school. Jessica blamed herself for her sister's shooting, and was mad that she was not able to protect her. She continues to have anger outbursts, but continues individual therapy to address this. Jessica also had a very strained relationship with her mother before the shooting. Jessica discusses now how this incident made her realize how important her family is to her. She and her mother became closer and she is now able to go to her mother for support.

Mother continues to struggle with her heart issues, but feels relieved to be living outside the city in a safer neighborhood. Mother admits that she had to make many changes, and feels that some of the decisions she has made has put her children at risk.

Handout 12: What's In Your Buckets?



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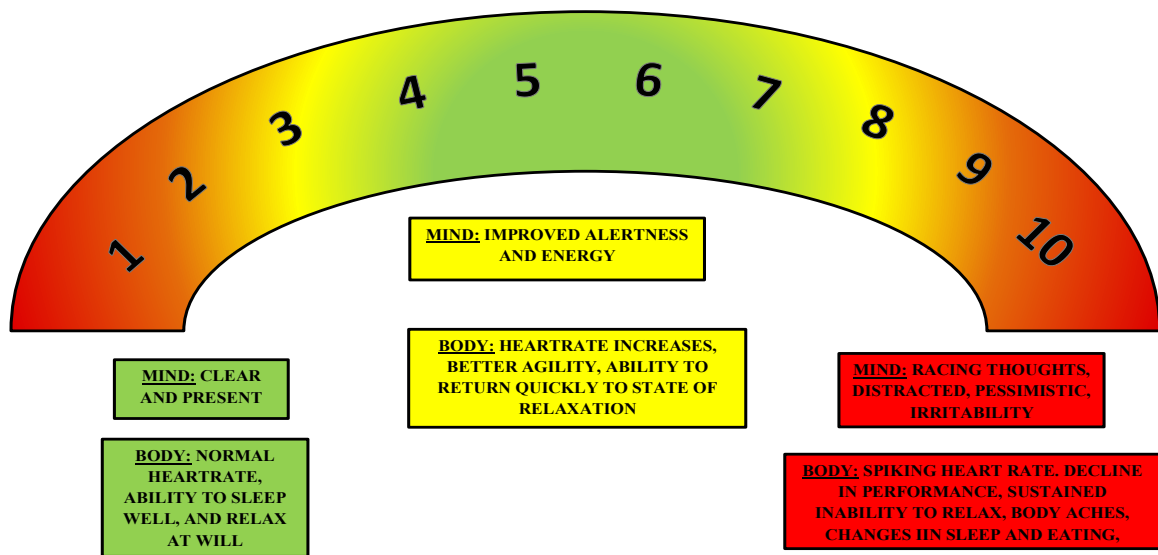
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APPENDIX B

Stress-Less Initiative Stress Scale (Vega & Menapace, 2017)



APPENDIX C

Stress-Less Initiative Implementation PowerPoint



Session 1: Introduction

**This is your group so come
and relax, share, and have
special time just to focus on
you!**

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Goals

- Early identification of STS, VT, and BO
- Increase awareness of our thoughts, feelings, behaviors and physical manifestations of stress
- Increase trust, safety, and cohesion
- Encourage proactive organizational support
- Normalize and validate secondary traumatic stress symptoms and remove stigma
- Learn approaches to reduce stress associated with providing trauma-informed services
- Acknowledge and celebrate the growth opportunities and rewards in this work

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Group Guidelines

- **Safe Space**
- **Trust**
- **Confidentiality**
- **Respect**

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Session Breakdown: A-L-P-S

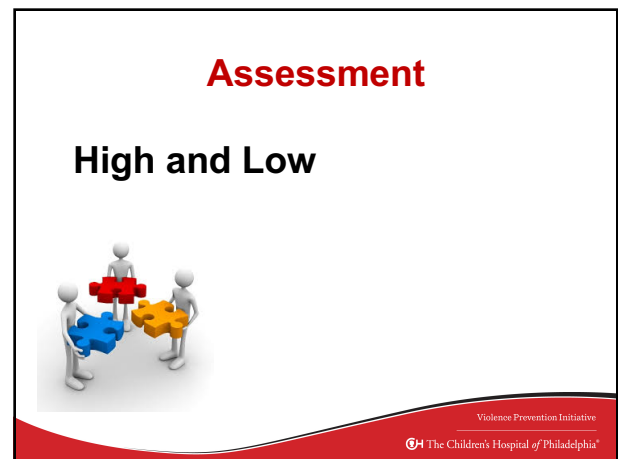
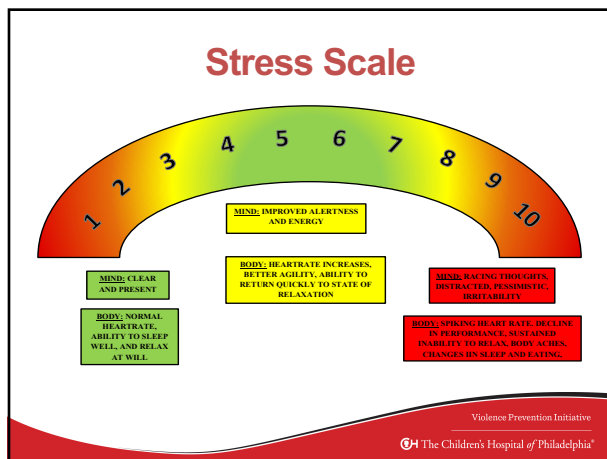
- **Assessment**
- **Learning**
- **Process**
- **Skill**

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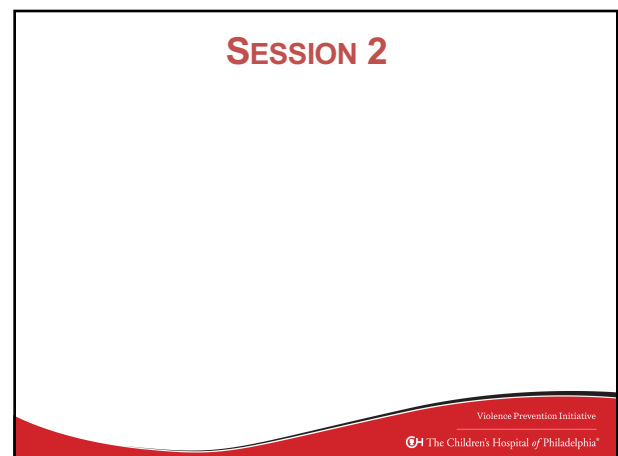
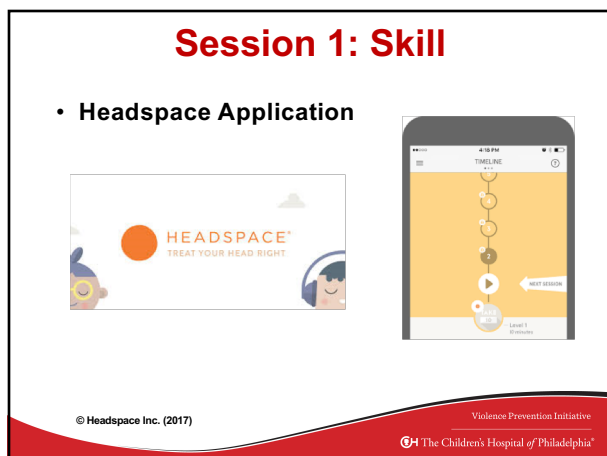
Session 1: Assessment

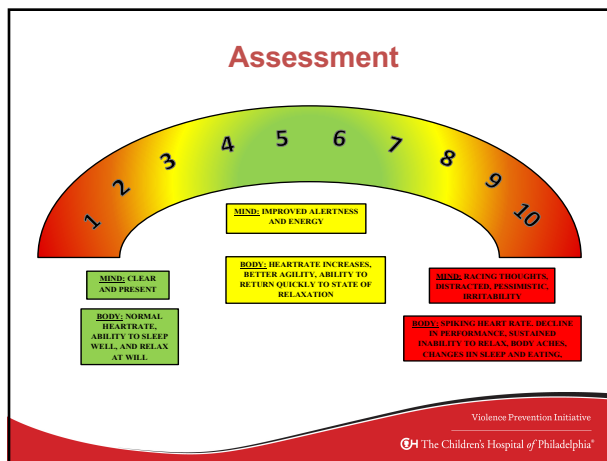
- It can be really hard to balance a demanding job, family, and friends and sometimes we don't get to stop and check-in with ourselves.
- It is important that we begin to check-in with ourselves daily. Often, we think about how stress affects us, but we don't always think about how stress affects our thoughts, feelings, body, and behaviors. It is important that we are able to identify these signs early so that we can reduce our stress and get back on track. Let's look at the visual stress scale and we will each state our stress level number to the group.

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- ### Session 1: Process
- What do you hope to get out of this group?
 - What goals do you have for yourself?
 - What do you see as your strengths in this work?
 - What are your challenges?
 - Are there things we can do as a team to support each other more?
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STS and VT

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary Traumatic Stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

Compassion fatigue, a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with the term.

Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professionals. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material.

Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.

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Symptoms

■ Hypervigilance	■ Minimizing	■ Fear	■ Inability to embrace complexity
■ Hopelessness	■ Anger and Cynicism	■ Chronic Exhaustion	■ Inability to listen or avoidance of clients
■ Guilt	■ Sleeplessness	■ Physical Ailments	■ Diminished Self-Care
■ Avoidance	■ Insensitivity to Violence	■ Disconnection	
■ Survival Coping	■ Anger or Cynicism	■ Poor Boundaries	
■ Social Withdrawal	■ Illness	■ Loss of Creativity	

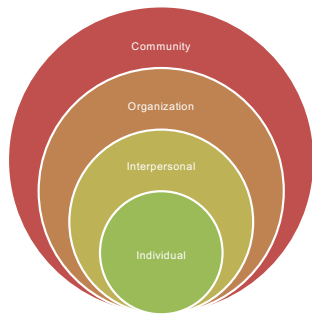
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Risk Factors

- Women
- Highly empathic
- Unresolved personal trauma
- Heavy caseloads
- Socially or professionally isolated
- Feel professionally compromised due to inadequate training

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Secondary Traumatic Stress



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Session 2: Process

- Can anyone share any difficult client experiences that they have gone through recently or in the past and how they affected you?
- Can anyone share some STS symptoms that they have experienced and things that helped to relieve the symptoms?

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Session 2: Skill

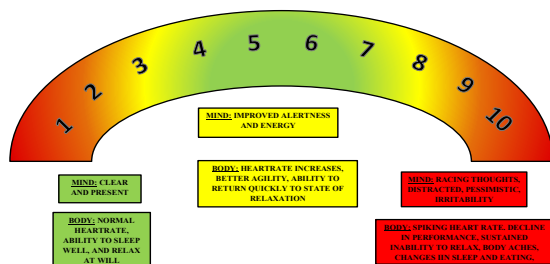


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SESSION 3

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Stress Scale, High-Low



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Our Journey: Professional Timeline

- Important values, people, places, or life events that influenced your career path
- Include both the positives and the negatives of your journey
- Only include what you are comfortable sharing with your team

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Session 3: Process

- Each member shares their timeline with the team and points out the decisions and values that led them to this work
- Do you share similar values and beliefs with other participants?
- As you hear some of your team members share, can you comment on some strengths you see in other members?

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Importance

- This exercise helped each of us realize what led us to do this work. For some of us, our timelines are just beginning and some of us have been in this field for several years. Some of you mentioned positive or negative events in your lives that led you in a certain direction, some mentioned positive or negative relationships that guided your path, and others mentioned opportunities that may have presented themselves along the way.

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Importance

- One thing we can take away from this activity is how unique we all are and that we all do very similar work but had very different paths getting to this place in our lives.

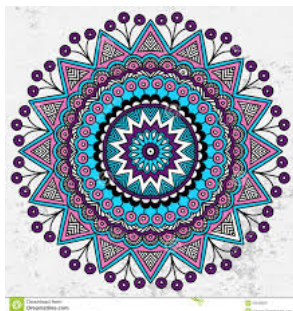
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Importance

- We all have our own individual histories, values, beliefs and culture, which affect how we engage in this work, how we perceive stress, and what we require to manage or reduce it.
- We are all so unique so we need to be able to identify our individual strengths as well as our limitations to increase our resilience and best support each other.

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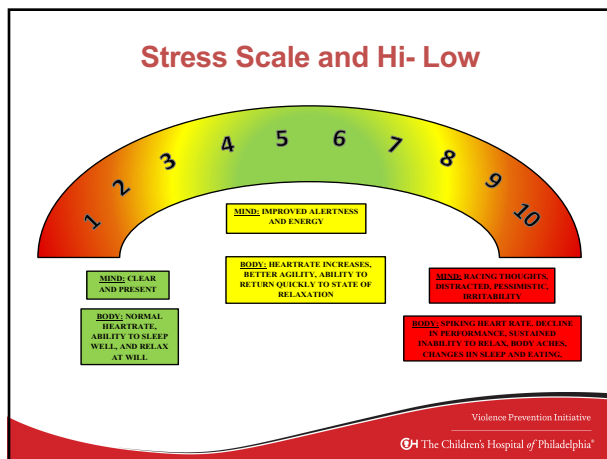
Session 3: Skill



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SESSION 4

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Power and Control

- Often the things that we don't have control over can cause us the most stress, and it is important to acknowledge and process our feelings about this in order to increase our resilience.
- How do issues of power and control affect us individually, our work with clients, and our work within systems?

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Power and Control

- What are some things that we don't have control over in our work?

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Power and Control

- What are some things that we do have control over in our work?

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Session 4: Process

- If you had unlimited power, what would you change?
- How do you manage the injustice that you see?
- What are things that have helped you let go of things you can't control?
- In what ways can you shift your resources or energy into the things you have control over in your work?

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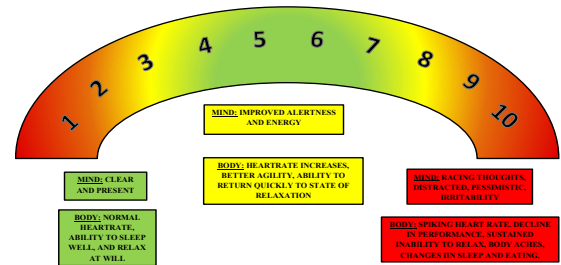
Session 4: Skill

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SESSION 5

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Stress Scale and High-Low



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Assessment

Provider Resilience app



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Empathy



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Personalization

When we practice from a slightly less personalized lens, we are not absorbing the trauma or loss that our patients often encounter

We are able to best serve our patients from this approach and also increase our own capacity, longevity, and personal health in this work

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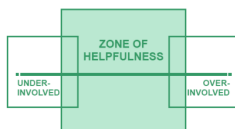
Empathy

- We can increase our empathy (and personalization) when it is needed to perform a certain function or during times that we want to feel the great rewards of this work
- We can decrease or mute our empathy (and personalization) at times of increased trauma exposure and we have an existing connection with our clients

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Empathy & Personalization

A Continuum of Professional Behavior



A zone of helpfulness is in the center of the professional behavior continuum. This zone is where the majority of client interactions should occur for effectiveness and client safety. Over-involvement with a client is on the right side of the continuum; this includes boundary crossings and boundary violations. Under-involvement lies on the left side; this includes distancing, disinterest and neglect, and it can also be detrimental to the client and the nurse. There are no definite lines separating the zone of helpfulness from the ends of the continuum; instead, it is a gradual transition or melding.

NCSBN, 2007

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Session 5: Process

- What are your thoughts about being able to control levels of empathy?
- Have you found ways to do this successfully?
- Does lessening our empathy mean that we care less?
- What are some barriers of this approach?
- What are some benefits of this approach?

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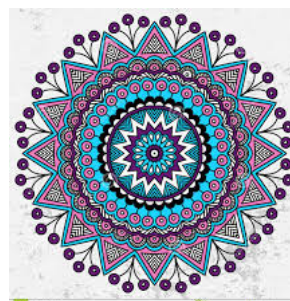
Personal Experience

- Can you think about a time in which you were really negatively impacted by a client experience?
- Can you reflect on what it was about this experience that affected you so much?

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Session 5: Skill



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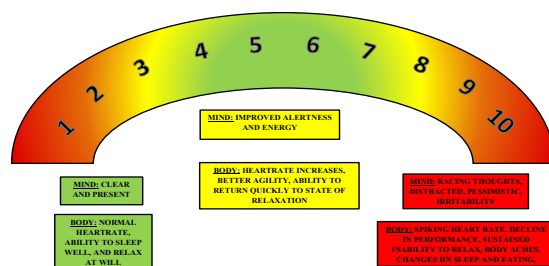
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SESSION 6

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Stress Scale, High-Low



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Plan for Resilience

- The goal of this session is to prepare each of us with clear steps of what to do when we experience overwhelming thoughts, feelings, behaviors, or physical symptoms related to our work.
- Having STS symptoms, is a normal reaction to the work we do

Plan for Resilience

- Stress can manifest in our thoughts, feelings, behaviors, and bodies and it is important when we check in with ourselves to think about all four of these domains. So often, we check in on one level and do not pay attention to all 4 domains.

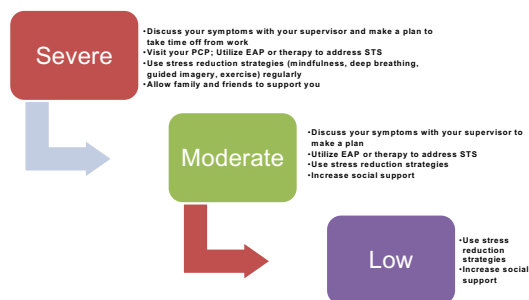
Symptoms Checklist

Hypervigilance	Hopelessness	Guilt	Avoidance	Survival Coping
Social Withdrawal	Minimizing	Anger and Cynicism	Sleeplessness	Insensitivity to Violence
Illness	Fear	Chronic Exhaustion	Physical Ailments	Disconnection
Poor Boundaries	Inability of Embrace Complexity	Inability to listen or avoidance of clients	Diminished Self-Care	

Plan for Resilience

- We all probably have experienced some of these symptoms at one time or another. I want to encourage us not to be ashamed of these symptoms or try to avoid them but to accept them, and look at them as signals to our body that we need to implement some strategies to reduce our stress response and feel better.

Wellness Action Plan



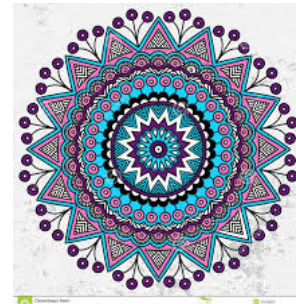
My Action Plan

Session 6: Process

- What symptoms do you think may manifest first (thoughts, feelings, behaviors, or body reactions)?
- Does anyone want to share any current symptoms they may be experiencing?
- Does anyone want to share how they may have overcome some stressful work times?
- What are your thoughts regarding the Wellness Action Plan?
- Do you think this is something that you will use if you find yourself experiencing intense symptoms?
- What are some of the self-care strategies you listed on your Action Plan?

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Session 6: Skill



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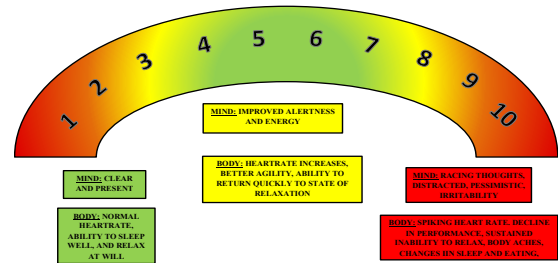
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SESSION 7

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Stress Scale and High- Low



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Rewards and Challenges

- **(Sexual Abuse Counselor):** "It's a balance between the terribleness of it and the awful, awful stories that you hear and the amazement of people, what they've made of their lives. Something quite different and their values. I mean I'm hugely affected by these, [stories] but they're really amazing. I'm constantly in awe really of some of the stories because, I mean, some I have to say: How on earth is this person still alive really? What is holding them?" (Pack, 2014)

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Rewards and Challenges

- Over time they developed the skills to create a delicate balance between being present for the client while at the same time not being "it" for the client.
(Trauma Therapist) "You can't be there for every child forever. You know, that is not my role. So, I'm separating from them, and that separation is sometimes extremely painful". (Lonergan, O'Halloran & Crane, 2004)

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Rewards and Challenges

- **(Trauma Therapist)** said “I think we don’t talk enough in graduate school and training about the experience of working with people in pain and the feeling that sometimes you can’t be helpful.” She made it clear that two important others in her life made a difference in helping her gain perspective: “During the worst time of my career, two people were instrumental. The DA called to remind me that I was not God and I couldn’t control the world, and a professor told me, “It’s not happening to you”. (Lonergan, O’Halloran & Crane, 2004)

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Rewards and Challenges

- **(Psychiatrist)** “The patients in the therapeutic relationship will want to please you, they will be aware of what we can handle, and may protect us by not giving us too much, just as they may have protected their parents. In order to keep yourself open to hearing what they bring, you have to monitor what is happening in yourself”. (Marriage & Marriage, 2005)

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Rewards and Challenges

- **(Psychologist)** “Working with dying patients gives me a perspective on what is important in life. At the end of the journey, most focus on relationships, rather than fame or fortune. And the experience humbles you...we are not always successful at saving patients. And then there is frustration and guilt- why do patients have to go through this?” (Marriage & Marriage, 2005)

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Rewards and Challenges

- **(Psychiatrist)** “Sharing the story with a colleague, reflecting on what it is like to sit with enormous trauma, can be part of an empathic exchange, a mentoring process. Realizing that times of sharing the worst stories are also times of potential growth for the patient. With longer experience, as you see people work through these things, it becomes easier to nurture a thread of hope for each client”. (Marriage & Marriage, 2005)

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Rewards and Challenges

- **(Social Worker)** “It touches you: you see the intimate parts of people’s lives. You realize there are more layers, gives you a different perspective-it is harder to be certain that things are not always what they seem. Your perspective changes as you learn more.... You must be emotionally available to be effective. So, you must keep a balance, while still being self-protective”. (Marriage & Marriage, 2005)

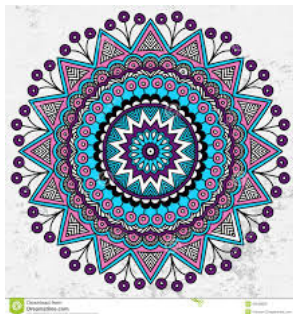
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Session 7: Process

- **What motivates you to do this work?**
- **How can we magnify/celebrate the rewards of this work more?**
- **What would decrease the challenges of this work?**

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Session 7: Skill

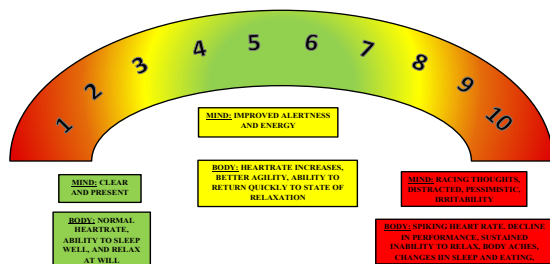


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SESSION 8

Violence Prevention Initiative
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Stress Scale and High-Low



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The Children's Hospital of Philadelphia

Assessment

Provider Resilience app



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The U in Trauma

- Trauma-informed care includes the understanding that we all come into this work with our own histories. As individuals working with clients who have undergone extensive trauma, it is critical to reflect on our own history and identify stressors and triggers that can potentially have a negative impact on us and our work with clients. If we know our triggers, then we are able to utilize resources during increased times of stress or when we are faced with our own triggers.

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Know Your Triggers

- Take 10 minutes and complete the exercise
- Discuss your stressors and triggers with the team and the resources you would utilize

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Session 8: Process

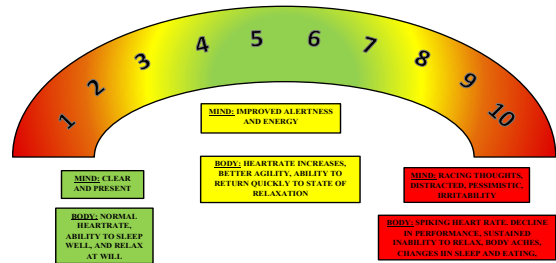
- Can you share a time that you have been triggered in this work?
- What did you do to cope?
- Are there things that would be helpful for your teammates to know to best support you during a stressful time?

Session 8: Skill



SESSION 9

Stress Scale & High-Low



BOUNDARIES

<https://www.youtube.com/watch?v=dTiNUP2KqWM>

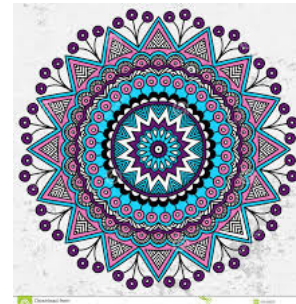
Boundaries

- Having good boundaries can be a challenge in our work because we work with such vulnerable populations. It is difficult when clients and families invite you into their lives at such vulnerable times, and the thought of creating boundaries can feel like we are putting up walls of separation when client and families may need us the most.
- Boundaries are not meant to divide us from our clients, but the everyday "yes" or "no's" help us balance our priorities, time, and energy.
- We are often taught that boundaries are there to protect our feelings but boundaries are as much for our clients as they are for us. We have an obligation to protect our clients and set realistic expectations with them.

Session 9: Process

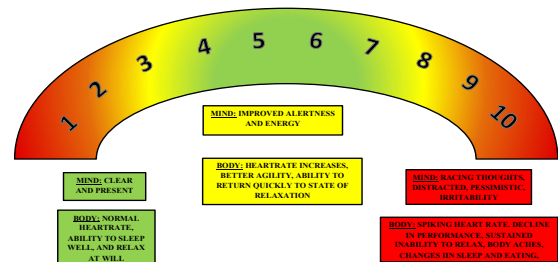
- Do you think having boundaries is important? Why or why not?
- What are some challenges of having to implement boundaries with clients?
- What are some signs that let us know that our energy is drained and we need to refuel?
- How can we implement boundaries and not make clients feel that we are pushing them away?

Session 9: Skill



SESSION 10

Stress Scale and High-Low



How do we measure success?

Maria 2013

Maria

- What are your reactions to this case?
- Name some of the strengths you heard?
- Name some of the challenges?
- What is your hope for Maria, for Jessica, for the family?
- How does it feel to have to close a case at this point?

What does success look like?

- How do you define success with your clients?
- How do you manage your expectations of what you hope the outcome will be?
- What are some strategies that can help us stay optimistic and positive despite our client's challenges?

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How do we measure success?

Maria 2015

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Importance

- If we reflect on our own timelines, we can often see that very difficult times in our own life, are followed by a period of growth for us. We don't always know what effect or meaning a particular experience (even a bad one) will have on a client's life or what potential growth can look like for that client.

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Session 10: Process

- Do you, do we (as an organization) take enough time to celebrate the small victories?
- How do we make meaning in this work?
- Are you able to see successes or positive experiences in difficult times?
- What are some protective factors you see in this work?
- Are our rewards in this work internal/external?

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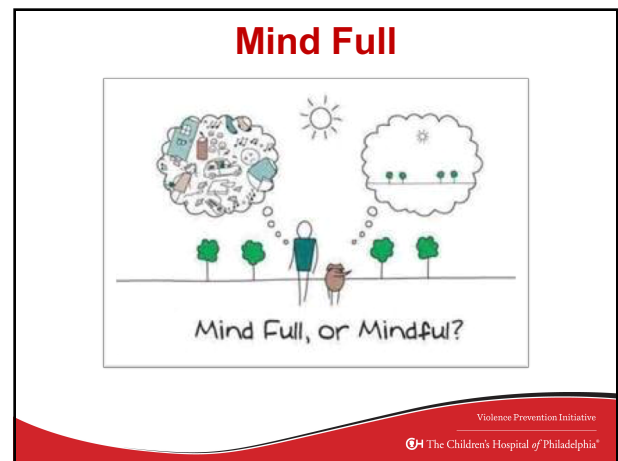
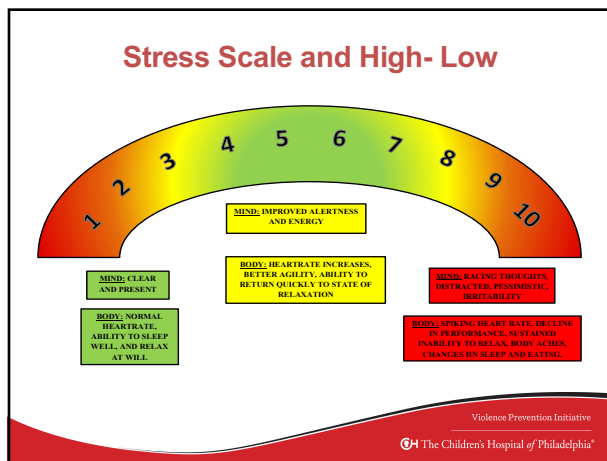
Session 10: Skill



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Session 11

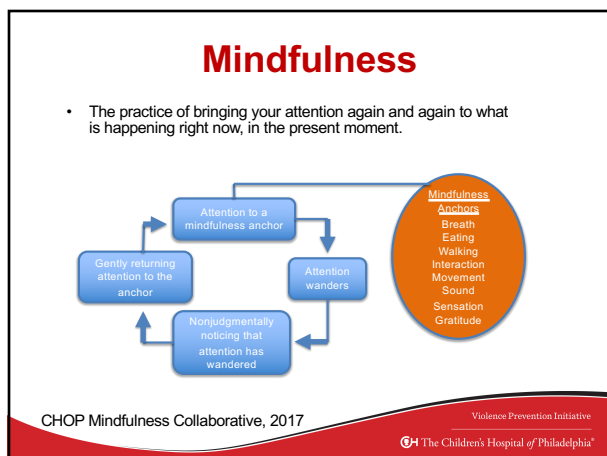
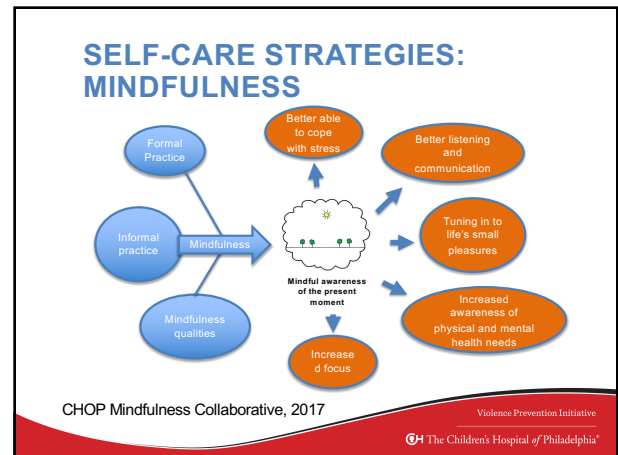
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Mindfulness

- <https://www.youtube.com/watch?v=aNCB1MZDgQA>
- <https://www.youtube.com/watch?v=1h-Zn9pKAU>

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Mindfulness

- Trains your mind to allow thoughts to be born, hover and then pass away
- Controlling reactions now to learn how to control them in the future
- Lower natural emotional arousal to prepare for real life
- More practice will make it easier to use in everyday life when you get "stuck" outside the moment!
- Keep your brain from telling your body when there is a false threat.

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Process

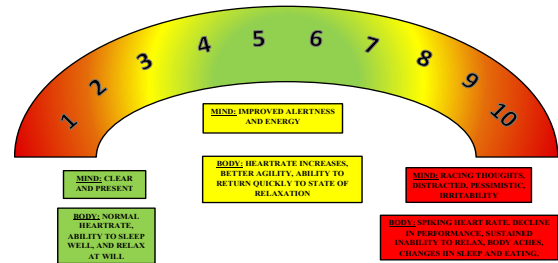
- How do you disconnect from work?
- Is it hard to be present at home?
- How are we supposed to connect and disconnect accordingly?
- How do we protect our own emotional health from the intensity of the trauma work we do?

Session 11: Skill



Session 12

Stress Scale & High- Low



Assessment

Provider Resilience app



Work/Life Balance



https://www.ted.com/talks/shawn_achor_the_happy_secret_to_better_work

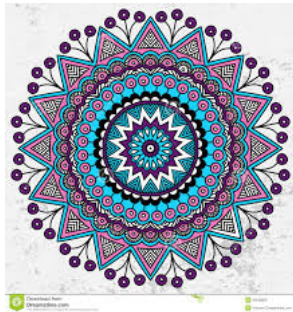
Self-Reflection

- What do you want your buckets to look like?
- How can you have more balance in your life?
- What is one thing you may need to change or give up to have more balance in your life?

Session 12: Process

- How do we distribute our time and energy across the buckets that are most important to us?
- How can we regularly reflect on our values, needs, and purpose so that we are living the life we want?

Session 12: Skill



Trauma Informed Agency Assessment

Guide to Completing the Agency Self-Assessment

Purpose

The Agency Self-Assessment for Trauma-Informed Care is intended to be a tool that will help you assess your organization's readiness to implement a trauma-informed approach. Honest and candid staff responses can benefit your agency by helping to identify opportunities for program and environmental change, assist in professional development planning, and can be used to inform organizational policy change.

How to Complete the Agency Self-Assessment

The *Self-Assessment* is organized into five main “domains” or areas of programming to be examined:

- Supporting Staff Development
- Creating a Safe and Supportive Environment
- Assessing and Planning Services
- Involving Consumers
- Adapting Policies

Agency staff completing the *Self-Assessment* are asked to read through each item and use the scale ranging from “strongly disagree” to “strongly agree” to evaluate the extent to which they agree that their agency incorporates each practice into daily programming. Staff members are asked to answer based on their experience in the program over the past twelve months.

Responses to the *Self-Assessment* items should remain anonymous and staff should be encouraged to answer with their initial impression of the question as honestly and accurately as possible. Remember, staff members are not evaluating their individual performance, but rather, the practice of the agency as a whole. Staff should complete the *Self-Assessment* when they have ample time to consider their responses; this may be completed in one sitting or section-by-section if time does not allow.

Agencies may distribute the tool in either Word or Excel format. Some agencies may prefer to use an electronic method (such as Survey Monkey) to assist with data collection and analysis.

How to Compile and Examine Self-Assessment Results

It is helpful for the agency to have a designated point person to collect completed assessments and compile the results. Detailed suggestions and The “Toolkit” are on the Trauma Informed Care Website <http://www.traumainformedcareproject.org/>

To identify potential areas for change, look for statements where staff responses are mostly “strongly disagree” and “disagree”; these are the practices that could be strengthened. In addition, pay attention to those responding with “do not know” as this could indicate that the practice is lacking, or perhaps there is a need for additional information or clarification. Finally, it is helpful to examine items where the range of responses is extremely varied. This lack of consistency among staff responses may be due to a lack of understanding about an item itself, a difference of perspective based on a person's role in the agency, or a misunderstanding on the part of some staff members about what is actually done on a daily basis.

This instrument was adapted from the National Center on Family Homelessness Trauma-Informed Organizational Self-Assessment and “Creating Cultures of Trauma- Informed Care: A Self Assessment and Planning Protocol” article by Roger D. Fallot, Ph.D. & Maxine Harris, Ph.D.

Trauma-Informed Organizational Self-Assessment

Please complete the assessment, reading each item and rating from strongly disagree to strongly agree based on your experience in the organization over the last year. Use your initial impression: **Remember you are evaluating the agency not your individual performance.**

Agency/Program: _____

Today's' Date: _____

Name of Staff (optional): _____

I. Supporting Staff Development

A. Training and Education	Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
Staff at all levels of the program receive training and education on the following topics:						
1 What traumatic stress is.						
2 How traumatic stress affects the brain and body.						
3 The relationship between mental health and trauma.						
4 The relationship between substance use and trauma.						
5 The relationship between homelessness and trauma.						
6 How trauma affects a child's development.						
7 How trauma affects a child's attachment to his/her caregivers.						
8 The relationship between childhood trauma and adult re-victimization (e.g. domestic violence, sexual assault).						
9 Different cultural issues (e.g. different cultural practices, beliefs, rituals).						
10 Cultural differences in how people understand and respond to trauma.						
11 How working with trauma survivors impacts staff.						
12 How to help consumers identify triggers (i.e. reminders of dangerous or frightening things that have happened in the past)						
13 How to help consumers manage their feelings (e.g. helplessness, rage, sadness, terror)						
14 De-escalation strategies (i.e. ways to help people to calm down before reaching the point of crisis)						
15 How to develop safety and crisis prevention plans.						
16 What is asked in the intake assessment.						
17 How to establish and maintain healthy professional boundaries.						

B. Staff Supervision, Support and Self-Care		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
18	Staff members have regular team meetings.						
19	Topics related to trauma are addressed in team meetings.						
20	Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress-reducing strategies).						
21	Staff members have a regularly scheduled time for individual supervision.						
22	Staff members receive individual supervision from a supervisor who is trained in understanding trauma.						
23	Part of supervision time is used to help staff members understand their own stress reactions.						
24	Part of supervision time is used to help staff members understand how their stress reactions impact their work with consumers.						
25	The agency helps staff members debrief after a crisis.						
26	The agency has a formal system for reviewing staff performance.						
27	The agency provides opportunities for on-going staff evaluation of the program/agency.						
28	The agency provides opportunities for staff input into program practices.						
29	Outside consultants with expertise in trauma provide on-going education and consultation.						

II. Creating a Safe and Supportive Environment

A. Establishing a Safe Physical Environment		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
1	Agency staff monitors who is coming in and out of the program/agency.						
2	Staff members ask consumers for their definitions of physical safety.						
3	The environment outside the organization is well lit.						
4	The common areas within the organization are well lit.						
5	Bathrooms are well lit.						
6	Consumers can lock bathroom doors.						

A. Establishing a Safe Physical Environment Continued		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
7	The organization incorporates child-friendly decorations and materials.						
8	The organization provides a space for children to play.						
9	The organization provides consumers with opportunities to make suggestions about ways to improve/change the physical space.						

B. Establishing a Supportive Environment		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
Information Sharing							
10	The organization reviews rules, rights and grievance procedures with consumers regularly.						
11	Consumers are informed about how the program responds to personal crises (e.g. suicidal statements, violent behavior and mandatory reports).						
12	Consumer rights are posted in places that are visible (e.g. room checks, grievance policies, mandatory reporting rules).						
13	Materials are posted about traumatic stress (e.g. what it is, how it impacts people, and available trauma-specific resources).						
Cultural Competence							
14	Program information is available in different languages.						
15	Staff &/or consumers are allowed to speak their native languages within the agency.						
16	Staff &/or consumers are allowed to prepare or have ethnic-specific foods.						
17	Staff shows acceptance for personal religious or spiritual practices.						
18	Outside agencies with expertise in cultural competence provide on-going training and consultation.						
Privacy and Confidentiality							
19	The agency informs consumers about the extent and limits of privacy and confidentiality (kinds of records kept, where/who has access, when obligated to make report to police/child welfare).						
20	Staff and other professionals do not talk about consumers in common spaces.						

		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
Privacy and Confidentiality Continued							
21	Staff does not talk about consumers outside of the agency unless at appropriate meetings.						
22	Staff does not discuss the personal issues of one consumer with another consumer.						
23	Consumers who have violated rules are approached in private.						
24	There are private spaces for staff and consumers to discuss personal issues.						
Safety and Crisis Prevention Planning							
For the following item, the term “safety plan” is defined as a plan for what a consumer and staff members will do if the consumer feels threatened by another person outside of the program.							
25	Written safety plans are incorporated into consumers’ individual goals and plans.						
For the following item, the term “crisis-prevention plan” is defined as an individualized plan for how to help each consumer manage stress and feel supported.							
26	Each consumer has a written crisis prevention plan which includes a list of triggers, strategies and responses which are helpful and those that are not helpful and a list of persons the consumer can go to for support.						
Open and Respectful Communication							
27	Staff members ask consumers for their definitions of emotional safety.						
28	Staff members practice motivational interviewing techniques with consumers (e.g. open-ended questions, affirmations, and reflective listening).						
29	The agency uses “people first” language rather than labels (e.g. ‘people who are experiencing homelessness’ rather than ‘homeless people’).						
30	Staff uses descriptive language rather than characterizing terms to describe consumers (e.g. describing a person as ‘having a hard time getting her needs met’ rather than ‘attention seeking’).						
Consistency and Predictability							
31	The organization has regularly scheduled procedures/opportunities for consumers to provide input.						
32	The organization has policy in place to handle any changes in schedules.						
33	The program is flexible with procedures if needed, based on individual circumstances.						

III. Assessing and Planning Services

A. Conducting Intake Assessments		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
The intake assessment includes questions about:							
1	Personal strengths.						
2	Cultural background.						
3	Cultural strengths (e.g. world view, role of spirituality, cultural connections).						
4	Social supports in the family and the community.						
5	Current level of danger from other people (e.g. restraining orders, history of domestic violence, threats from others).						
6	History of trauma (e.g. physical, emotional or sexual abuse, neglect, loss, domestic/community violence, combat, past homelessness).						
7	Previous head injury.						
8	Quality of relationship with child or children (i.e. caregiver/child attachment)						
9	Children's trauma exposure (e.g. neglect, abuse, exposure to violence)						
10	Children's achievement of developmental tasks.						
11	Children's history of mental health issues.						
12	Children's history of physical health issues.						
Intake Assessment Process							
13	There are private, confidential spaces available to conduct intake assessments.						
14	The program informs consumers about why questions are being asked.						
15	The program informs consumers about what will be shared with others and why.						
16	Throughout the assessment process, the program staff observes consumers on how they are doing and responds appropriately.						
17	The program provides an adult translator for the assessment process if needed.						

Intake Assessment Follow-Up							
18	Based on the intake assessment, adults &/or children are referred for specific services as necessary.						
19	Re-assessments are done on an on-going and consistent basis.						
20	The program updates releases and consent forms whenever it is necessary to speak with a new provider.						
B. Developing Goals and Plans							
21	Staff collaborates with consumers in setting their goals.						
22	Consumer goals are reviewed and updated regularly.						
23	Before leaving the program, consumers and staff develop a plan to address any future needs.						
C. Offering Services and Trauma-Specific Interventions							
24	The program provides opportunities for care coordination for services not provided within that organization.						
25	The program educates consumers about traumatic stress and triggers.						
26	The program has access to a clinician with expertise in trauma and trauma-related interventions (on-staff or available for regular consultation).						

IV. Involving Consumers

A. Involving Current and Former Consumers		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
1	Current consumers are given opportunities to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways (e.g. suggestion boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc)						
2	The program recruits former consumers to serve in an advisory capacity.						
3	Former consumers are invited to share their thoughts, ideas and experiences with the program.						

V. Adapting Policies

A. Creating Written Policies		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
1	The program has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.						
2	Written policies are established based on an understanding of the impact of trauma on consumers and providers.						
3	The program has a written commitment to demonstrating respect for cultural differences and practices.						
4	The program has written policy to address potential threats to consumers and staff from natural or man- made threats (fire, tornado, bomb threat, and hostile intruder).						
5	The program has a written policy outlining program responses to consumer crisis/staff crisis (i.e. Self harm, suicidal thinking, and aggression towards others).						
6	The program has written policies outlining professional conduct for staff (e.g. boundaries, responses to consumers, etc).						
B. Reviewing Policies							
1	The program reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.						
2	The program involves staff in its review of policies.						
3	The program involves consumers in its review of policies.						

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APPENDIX E

Stress-Less Initiative Pre/Post Surveys

Stress-Less Initiative©

Name: _____ **Age:** _____ **Gender:** M F **Other:** ☐

Race _____ **Hispanic/Latino:** Yes / No

Job title: _____

Years in field: <1 1-3 4-6 7-9 10+

Caseload size: 1-10 11-13 14-16 17-19 20+ N/A

How often do you receive individual supervision?

Weekly 2 times per month Once per month Less than once per month N/A

How often do you receive group supervision?

Weekly 2 times per month Once per month Less than once per month N/A

The questions in this scale ask you about your feelings and thoughts during the last 30 days.

0 = never 1 = Almost never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3. In the last month, how often have you felt nervous and “stressed”?	0	1	2	3	4
4. In the last month, how often have you felt confident about your Ability to handle your personal problems?	0	1	2	3	4
5. In the last month, how often have you felt that things were going your way?	0	1	2	3	4
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. In the last month, how often have you been able to control irritations in your life?	0	1	2	3	4
8. In the last month, how often have you felt that you were on top of things?	0	1	2	3	4

	0 = never	1 = Almost never	2 = Sometimes	3 = Fairly Often	4 = Very Often
9. In the last month, how often have you been angered because of things that were outside of your control?	0	1	2	3	4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
11. I am happy.	1	2	3	4	5
12. I am preoccupied with more than one person I help.	1	2	3	4	5
13. I get satisfaction from being able to help people.	1	2	3	4	5
14. I feel connected to others.	1	2	3	4	5
15. I jump or am startled by unexpected sounds.	1	2	3	4	5
16. I feel invigorated after working with those I help.	1	2	3	4	5
17. I find it difficult to separate my personal life from my life as a helper.	1	2	3	4	5
18. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.	1	2	3	4	5
19. I think that I might have been affected by the traumatic stress of those I help.	1	2	3	4	5
20. I feel trapped by my job as a helper.	1	2	3	4	5
21. Because of my helping, I have felt "on edge" about various things.	1	2	3	4	5
22. I like my work as a helper.	1	2	3	4	5
23. I feel depressed because of the traumatic experiences of the people I help.	1	2	3	4	5
24. I feel as though I am experiencing the trauma of someone I have helped.	1	2	3	4	5
25. I have beliefs that sustain me.	1	2	3	4	5
26. I am pleased with how I am able to keep up with helping techniques and protocols.	1	2	3	4	5
27. I am the person I always wanted to be.	1	2	3	4	5
28. My work makes me feel satisfied.	1	2	3	4	5

	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
29. I feel worn out because of my work as a helper.	1	2	3	4	5
30. I have happy thoughts and feelings about those I help. and how I could help them.	1	2	3	4	5
31. I feel overwhelmed because my case [work] load seems endless.	1	2	3	4	5
32. I believe I can make a difference through my work.	1	2	3	4	5
33. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.	1	2	3	4	5
34. I am proud of what I can do to help.	1	2	3	4	5
35. As a result of my helping, I have intrusive, frightening thoughts.	1	2	3	4	5
36. I feel "bogged down" by the system.	1	2	3	4	5
37. I have thoughts that I am a "success" as a helper.	1	2	3	4	5
38. I can't recall important parts of my work with trauma victims.	1	2	3	4	5
39. I am a very caring person.	1	2	3	4	5
40. I am happy that I chose to do this work.	1	2	3	4	5

Please the one number for each question that comes closest to reflecting your opinion about it.

1 = Disagree very much 2 = Disagree moderately 3 = Disagree slightly 4 = Agree slightly

5 = agree moderately 6 = agree very much

41. I feel I am being paid a fair amount for the work I do.	1	2	3	4	5	6
42. There is really too little chance for promotion on my job.	1	2	3	4	5	6
43. My supervisor is quite competent in doing his/her job.	1	2	3	4	5	6
44. I am not satisfied with the benefits I receive.	1	2	3	4	5	6
45. When I do a good job, I receive the recognition for it that I should receive.	1	2	3	4	5	6
46. Many of our rules and procedures make doing a good job difficult.	1	2	3	4	5	6
47. I like the people I work with.	1	2	3	4	5	6
48. I sometimes feel my job is meaningless.	1	2	3	4	5	6
49. Communications seem good within this organization.	1	2	3	4	5	6
50. Raises are too few and far between.	1	2	3	4	5	6

**1 = Disagree very much 2 = Disagree moderately 3 = Disagree slightly 4 = Agree slightly
5 = Agree moderately 6 = Agree very much**

51. Those who do well on the job stand a fair chance of being promoted.	1	2	3	4	5	6
52. My supervisor is unfair to me.	1	2	3	4	5	6
53. The benefits we receive are as good as most other organizations offer.	1	2	3	4	5	6
54. I do not feel that the work I do is appreciated.	1	2	3	4	5	6
55. My efforts to do a good job are seldom blocked by red tape.	1	2	3	4	5	6
56. I find I have to work harder at my job because of the incompetence of people I work with.	1	2	3	4	5	6
57. I like doing the things I do at work.	1	2	3	4	5	6
58. The goals of this organization are not clear to me.	1	2	3	4	5	6
59. I feel unappreciated by the organization when I think about what they pay me.	1	2	3	4	5	6
60. People get ahead as fast here as they do in other places.	1	2	3	4	5	6
61. My supervisor shows too little interest in the feelings of subordinates.	1	2	3	4	5	6
62. The benefit package we have is equitable.	1	2	3	4	5	6
63. There are few rewards for those who work here.	1	2	3	4	5	6
64. I have too much work to do at work.	1	2	3	4	5	6
65. I enjoy my coworkers.	1	2	3	4	5	6
66. I often feel that I do not know what is going on with the organization.	1	2	3	4	5	6
67. I feel a sense of pride in doing my job.	1	2	3	4	5	6
68. I feel satisfied with my chances for salary increases.	1	2	3	4	5	6
69. There are benefits we do not have which we should have.	1	2	3	4	5	6
70. I like my supervisor.	1	2	3	4	5	6
71. I have too much paperwork.	1	2	3	4	5	6
72. I don't feel my efforts are rewarded the way they should be.	1	2	3	4	5	6
73. I am satisfied with my chances for promotion.	1	2	3	4	5	6
74. There is too much bickering and fighting at work.	1	2	3	4	5	6
75. My job is enjoyable.	1	2	3	4	5	6
76. Work assignments are not fully explained.	1	2	3	4	5	6

Please say how much you agree or disagree with each of the following statements by selecting from the following:

1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree N/A=Does not apply

77. My coworkers listen to me when I need to talk about work-related problems.	1	2	3	4	N/A
78. My coworkers help me with difficult tasks.	1	2	3	4	N/A
79. My coworkers help me in crisis situations at work.	1	2	3	4	N/A

Please indicate the degree of your agreement or disagreement with each statement by filling in the circle on your answer sheet that best represents your point of view. Please choose from the following answers:

**0= strongly disagree 1 = moderately disagree 2 = slightly disagree 3 = neither agree nor disagree
4= slightly agree 5= moderately agree 6= strongly agree**

80. The supervisor values my contribution to its well-being.	0	1	2	3	4	5	6
81. The supervisor fails to appreciate any extra effort from me.	0	1	2	3	4	5	6
82. The supervisor would ignore any complaint from me.	0	1	2	3	4	5	6
83. The supervisor really cares about my well-being.	0	1	2	3	4	5	6
84. Even if I did the best job possible, the supervisor would fail to notice.	0	1	2	3	4	5	6
85. The supervisor cares about my general satisfaction at work.	0	1	2	3	4	5	6
86. The supervisor shows very little concern for me.	0	1	2	3	4	5	6
87. The supervisor takes pride in my accomplishments at work.	0	1	2	3	4	5	6

Please indicate the degree of your agreement or disagreement with each statement by selecting the answer that best represents your point of view. Please choose from the following answers:

0= strongly disagree 1 = moderately disagree 2 = slightly disagree 3 = neither agree nor disagree
4= slightly agree 5= moderately agree 6= strongly agree

88. The organization values my contribution to its well-being.	0	1	2	3	4	5	6
89. The organization fails to appreciate any extra effort from me.	0	1	2	3	4	5	6
90. The organization would ignore any complaint from me.	0	1	2	3	4	5	6
91. The organization would ignore any complaint.	0	1	2	3	4	5	6
92. Even if I did the best job possible, the organization would fail to notice.	0	1	2	3	4	5	6
93. The organization cares about my general satisfaction at work.	0	1	2	3	4	5	6
94. The organization shows very little concern for me.	0	1	2	3	4	5	6
95. The organization takes pride in my accomplishments at work.	0	1	2	3	4	5	6